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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Health and Social Care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Department of Health (DoH) and are available on our website at **www.rqia.org.uk**.

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- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how we intend to demonstrate our effectiveness and impact as a regulator.

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We wish to thank everyone who facilitated this review through participating in interviews, providing relevant information and/or facilitating our Review Team.

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

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Abbreviations

BSO	Business Services Organisation
CCG	Clinical Communications Gateway
CVI	Certification of Visual Impairment
DEP	Developing Eyecare Partnerships
DoH	Department of Health
ECLO	Eye Clinic Liaison Officer
GP	General Medical Practitioner
HSC Board	Health and Social Care Board
LES	Local Enhanced Service
NIECR	Northern Ireland Electronic Care Record
PPI	Personal and public involvement
Project ECHO	Project Extension for Community Healthcare Outcomes
QUB	Queens University Belfast
SPEARS	Southern Primary Eyecare Assessment and Referral Service

Executive Summary

In 2012, the Department of Health[2] (DoH) published the Developing Eyecare Partnerships (DEP) Strategy[3] which set out the strategic direction for improving the commissioning and provision of eyecare services in Northern Ireland over a five year period.

Implementation of the DEP Strategy has been sponsored and overseen by the DoH. The Health and Social Care Board (HSC Board) and Public Health Agency (PHA) have co-led on implementation of the DEP Strategy over the five year period from 2013 to 2017. A DEP project was established to deliver the DEP Strategy which was subsequently managed through five separate Task Groups, each with assigned objectives, with oversight provided by the DEP Project Board. This review assessed the implementation process (DEP project) and also considered how effective the DEP Strategy has been in relation to service improvement.

The Review Team found support for the DEP project among stakeholders involved in its implementation including representatives from education, primary care and service users. The DEP Strategy was considered by stakeholders to have facilitated service improvement and development.

Despite a complicated structure and slower pace of progress, the Review Team considers that the implementation process for the DEP project has generally been effective. Going forward, following the standing down of the DEP project, an Eyecare Network (successor to DEP) should now be established. This network should be facilitated by the HSC Board, should involve greater clinical input and should have a greater focus on implementation of service improvement.

The Review Team also assessed the achievements of the various strands of the DEP project, the changes made to how services are delivered and the resulting improvements for service users. The Review Team supports the work that has already been carried out in development of two locally enhanced services to improve care for patients with suspected ocular hypertension or glaucoma. The Review Team recommends the further spread and scale of the Southern Primary Eyecare Assessment and Referral Service (SPEARS).

The Review Team commends the work undertaken in the development of cataract and macular degeneration pathways; however the Review Team considers that further work needs to be carried out in the development of primary care based cataract enhanced services, particularly in relation to post-operative care.
The Review Team considers these initiatives, in conjunction with the development of more effective pathways and appropriate training, will result in a larger number of patients being managed safely in primary care, thus reducing the pressure on secondary care services.

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[2] Formerly known as the Department of Health and Social Services and Public Safety (DHSSPS)
[3] Developing Eyecare Partnerships - Improving the Commissioning and Provision of Eyecare Services in Northern Ireland - http://www.hscbusiness.hscni.net/pdf/DEVELOPING_EYECARE_PARTNERSHIPS_2012(1).pdf

While the Review Team saw evidence of good progress across a number of areas, they identified a particular concern regarding the increasing demand for ophthalmology services within secondary care. The Review Team was particularly concerned that patients may be coming to harm as a result of delays in new and review appointments within secondary care for a range of eye conditions, including wet age-related macular degeneration, glaucoma and diabetic retinopathy.

In September 2016, 4,543 people in Northern Ireland were waiting for more than one year for a first ophthalmology outpatient appointment. By March 2017 this number had risen to 6,986 people. In updated data for March 2018 supplied by the HSC Board this number had risen to 10,159 people.

The Review Team recommends that the DoH in conjunction with the HSC Board and PHA, exercises its responsibility for patient safety and increases its focus on the current waiting list for eyecare services, particularly the excessive waiting times for a first and further follow up outpatient appointments.

The Review Team supports the various health promotion initiatives facilitated and supported by the DEP project. As the work of the DEP project comes to an end the Review Team recommends that these valuable health promotion initiatives should continue.

The Review Team welcomes establishment of the Clinical Communications Gateway, with a capacity for electronic referral from primary care optometry to secondary care ophthalmology services. This system facilitates e-Triage and provides an opportunity for development of more effective communication between primary and secondary care services. The Review Team recommends the spread and scale of access to the Clinical Communications Gateway.

Having reviewed the outcomes from the work of the DEP project, the Review Team makes nine recommendations aimed at consolidating the work of the project and facilitating the future development of eyecare services across Northern Ireland.

Section 1: Introduction

1.1 Context for the Review

Good eyesight is something most people take for granted. However, that is not the case for everyone and blindness or sight loss can have a profound effect on individuals and their families. As people get older, they are increasingly likely to experience sight loss and as of 2015, over two million people in the United Kingdom are living with sight loss[4].

As a result of the ageing population, the number of people in Northern Ireland with sight loss is set to increase dramatically. Age-related macular degeneration is the main cause of sight loss or visual impairment in adults.

It is estimated that half of sight impairment in the United Kingdom is preventable. Prevention and early detection of sight threatening conditions, in both adults and children, are essential to improve eye health[5].

The treatment and management of acute and long term eye conditions such as glaucoma, cataract and macular degeneration, can significantly contribute to an individual's independence and to helping them to lead a more fulfilling life.

In 2012, the DoH published the Developing Eyecare Partnerships Strategy (referred to onwards as the DEP Strategy)[6] which set out the strategic direction for improving the commissioning and provision of eyecare services in Northern Ireland.

The strategy drew on evidence of best practice, including guidance from the National Institute for Health and Clinical Excellence[7]. It also took account of evaluations undertaken in England[8], Wales[9], and Scotland[10], of the commissioning and provision of innovative partnership approaches to delivering eyecare services in both the community and hospital sectors.

Implementation of the DEP Strategy across Health and Social Care in Northern Ireland was managed and monitored using a project management structure, which included development of specific Task Groups with defined reporting pathways.

This review appraises the implementation process and also considers how effective the DEP Strategy has been in relation to service improvement.

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[4] https://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics
[5] https://www.rnib.org.uk/professionals/knowledge-and-research-hub/key-information-and-statistics
[6] Developing Eyecare Partnerships - Improving the Commissioning and Provision of Eyecare Services in Northern Ireland - http://www.hscbusiness.hscni.net/pdf/DEVELOPING_EYECARE_PARTNERSHIPS_2012(1).pdf
[7] National Institute for Health and Clinical Excellence, www.nice.org.uk
[8] *General Ophthalmic Services Review* (2007) Department of Health England; *Commissioning Toolkit for Community based Eyecare Services (2007),* Department of Health England.
[9] *The Welsh Eye Care initiative,* funded by the Welsh Government; Also, *Wales Vision Strategy, Implementation Plan* 2010-2014, Welsh Advisory Group, linked to the UK Vision Strategy;
[10] *Review of Community Eyecare Services in Scotland: Final Report (*2006). Scottish Government.

1.2 Terms of Reference

The terms of reference for this review were to:

1. Appraise the implementation process associated with the DEP Strategy;
2. Assess the effectiveness and impact to date, of the DEP Strategy, on the delivery and development of services;
3. Consider how service users and carers, staff and the wider public have been involved in the implementation of the DEP Strategy (including planning, evaluation and review);
4. Identify any lessons learned from implementation of the DEP Strategy which are relevant to the remaining implementation process;
5. Report on the findings, making recommendations as appropriate, to inform the planned end of life cycle review of the DEP Strategy.

1.3 Review Methodology and Scope

This RQIA initiated review was undertaken as part of RQIA's Three Year Review Programme 2015-2018. The fieldwork for this review was completed in March 2017.

This review used the following methodologies:

1. A literature review to examine similar partnership projects, best practice in provision of ophthalmic services and recent reviews of ophthalmic services in the United Kingdom;
2. A profiling exercise to collect information on the current configuration of eyecare services across Northern Ireland;
3. Interviews with representatives from education, primary care, secondary care, commissioning groups and organisations representing service users, to consider the effectiveness and impact to date of the DEP Strategy;
4. Provision of a report of findings which includes recommendations for improvement.

Section 2: The Strategy for the Development of Eyecare Partnerships

The overarching objectives of this regional strategy were to minimise sight loss and reduce health inequalities. When published by the DoH the 2012, the DEP Strategy[11] set out four overarching aims as follows:

1. To identify potential sight-threatening problems at a much earlier stage;
2. To contribute to the independence of adults, maintaining them well in the community for as long as possible by improving access to current HSC treatment for acute and/or long-term eye conditions;
3. To contribute to the improvement of life chances for children, including those children living with disabilities, through improving access to eyecare services and treatment for acute and long-term conditions;
4. To maximise use of HSC resources in both primary and secondary care services.

2.1 Developing Eyecare Partnerships Project

The implementation of the DEP Strategy has been sponsored and overseen by the DoH. The HSC Board and PHA have co-led on the implementation of the DEP Strategy over the five year period from 2013 to 2017.

The DEP project[12] was established to deliver the DEP Strategy by facilitating the development of care pathways across all sub-specialties as appropriate, from primary care through to specialised secondary care, utilising the expertise of a variety of staff and a range of skills.

Organisations were invited to nominate members to sit on the DEP Project Board. Chaired by the Director of Integrated Care in the HSC Board, the DEP Project Board included 22 members (see Appendix 2). Membership was drawn from those with experience in clinical delivery of eyecare, management of eyecare services, the field of academia and professional training, and from the voluntary sector with particular emphasis on vision and service provision for visually impaired persons.

Implementation of the DEP project was managed through a structure comprising five Task Groups (outlined overleaf) with dedicated work streams, each with assigned terms of reference and objectives (see Appendix 3).

[11] Developing Eyecare Partnerships - Improving the Commissioning and Provision of Eyecare Services in Northern Ireland - http://www.hscbusiness.hscni.net/pdf/DEVELOPING_EYECARE_PARTNERSHIPS_2012(1).pdf

[12] http://www.hscboard.hscni.net/our-work/integrated-care/ophthalmic-services/developing-eye-care-partnerships/

- Task Group 1 - Workforce and Legislative Issues
- Task Group 2 - Integrated Models/Pathways
- Task Group 3 - Regional Measurement
- Task Group 4 - Regional Acute Eye Pathway
- Task Group 5 - Promotion of Eye Health

A further three Task Groups were subsequently established; the Certification of Visual Impairment (CVI) Subgroup, the Research Group and the 10,000 Voices Working Group. Underpinning the four primary aims of the DEP Strategy, twelve strategic objectives were agreed which were then thematically grouped and assigned across the Task Groups (see Appendix 3)

Terms of reference were established for the project and for each Task Group (see Appendix 4). A project manager was appointed in 2014 and they joined Task Group Leads as members of the DEP Project Team.

Personal and public involvement (PPI) was considered to be integral to the work of the DEP project, to ensure the needs and values of individuals and families were heard and actively taken into account. The DEP project aimed to provide accessible opportunities for involvement of service users, patients, carers and the public at all levels ensuring that any identified barriers to engagement were overcome.

Section 3: Findings from the Review

This section sets out the findings arising from this review which are described under eight main themes.

3.1 The Implementation Process

In relation to the leadership and governance of the DEP project, the majority of stakeholders involved reported to us that the DEP project had been well defined and supported by an excellent project management structure; regular updates were provided to the Project Board from each of the Task Groups, discussions and decisions taken were accurately and comprehensively recorded.

The Review Team considers that the objectives of the DEP Strategy did not fully match up with the overall DEP project aims as subsequently set out, which meant that full delivery of the strategy was going to be challenging from the outset. When linking progress made, to the strategic objectives, the Review Team considers that, particularly in relation to the aim of identification of potentially sight-threatening problems at a much earlier stage, the implementation process has not fully delivered this objective.

During our review, some concerns were raised by DEP stakeholders from education, primary and secondary care, commissioning and service user representatives regarding the pace of progress. There was also some criticism regarding the large number and the composition of Task Groups within the DEP project structure.

On review of the membership of the Task Groups, the Review Team noted that there were relatively few clinicians from either secondary care or from primary optometric care, while there was a larger representation from non-clinical stakeholder groups.

General Medical Practitioners were represented on Task Groups by both HSC Board employed Medical Advisors and General Medical Practitioners. However, input from General Medical Practitioners was difficult to secure due to their day to day work commitments. It should be noted that service improvement initiatives, e.g. pathway reform and the use of e-Referral, have routinely been shared with the Northern Ireland General Practitioner Committee of the British Medical Association. The Review Team considered that this routine sharing of information aided the implementation process by providing opportunities for input from general practice throughout.

The DEP project was considered by both optometric and ophthalmic clinical staff, involved in the project, to have been very successful in developing better linkages between secondary care ophthalmologists, the primary care optometry community and the HSC Board. However, the Review Team was told by secondary care clinicians that difficulties in balancing their ongoing clinical commitments, affected their ability to fully contribute to the DEP project. This did not slow the implementation process, but meant that meaningful input of clinicians was not fully achieved.

In addition to the DEP project implementation plan, a significant workforce training and development plan was developed to underpin the entire DEP project. This was in place to ensure that training and workforce requirements to support service developments were recognised and appropriately addressed. The existence of the training and development plan, linked across three of the Task Groups, has ensured that where resources were likely to be required these were flagged to the HSC Board and DoH at an early stage.

In relation to overall implementation of the DEP project, the Review Team specifically noted a number of positive developments:

- A primary care optometry Local Enhanced Service (LES) for glaucoma/ocular hypertension;
- A rapid access referral protocol for suspected wet age-related macular degeneration;
- The Southern Primary Eyecare Assessment and Referral Service (SPEARS);
- Training and professional development including the Project ECHO® (extension for community healthcare outcomes) initiative;
- Information, communication & technology enhancements including access to the Clinical Communications Gateway for primary care optometrists;
- A number of health promotion campaigns.

The DEP implementation project concluded in October 2017. The Review Team considers that it is important that work already completed or underway is given time to come to fruition and to fully bed in, and that further work in developing eyecare services is agreed and facilitated. In the main, both the Review Team and DEP project stakeholders were positive about the work of the DEP project and would support a future structure/road-map for a successor programme.

The DEP project structure assisted in the development of partnerships and joint initiatives and ensured that work was commenced in several important service areas. Further work could be managed by an Eyecare Network (successor to DEP), sponsored by the DoH and facilitated by the HSC Board. This would ensure continued service development and reconfiguration within existing management and clinical structures, along with further development of the necessary clinical relationships.

As part of future service development, improved dialogue and strengthening of partnerships between secondary care ophthalmologists and primary care optometrists will be necessary to deliver integrated eyecare services and to facilitate required service changes.

In view of this, the Review Team recommends that the DEP project structure is replaced by an Eyecare Network (successor to DEP) that is more focused on the continued spread and scale, refinement and delivery of integrated care using the emerging products of the DEP project. The Eyecare Network (successor to DEP) may choose to utilise Task and Finish groups with definite end dates to progress work in specific areas. The next phase of work should be supported by a much smaller infrastructure. A stronger clinical focus with more clinical input is required, as is an emphasis on implementation and evaluation of improvements delivered.

Recommendation 1	Priority 2
a) The current DEP implementation project structure should be stood down. An Eyecare Network (successor to DEP) sponsored by DoH and hosted by the HSC Board should be established to continue work in developing eyecare services. b) The Eyecare Network (successor to DEP) should focus on the continued evaluation, spread and scale, refinement and delivery of integrated eyecare services across Northern Ireland. c) Increased clinical input and a stronger clinical focus are required for the Eyecare Network's (successor to DEP) work programme going forward.	

3.2 Patient Safety: Waiting Lists and Delays to Follow Up

The Review Team recognises that hospital and community eyecare services are currently under significant pressure in Northern Ireland. The Review Team was particularly concerned about the increasing demand for ophthalmology services within secondary care. The reasons for this increase in demand were explored and the Review Team was advised that the increase is influenced by a range of factors including changing demography, increased referral rates and absence of funding to commission additional services from independent sector providers.

In September 2016, 21,792 people in Northern Ireland were waiting for their first ophthalmology outpatient appointment. Of these, 16,135 were waiting in excess of the ministerial target of nine weeks and over a quarter (4,543 people) were waiting more than one year.

At the time of this review in March 2017, this number had risen to 24,460 people waiting for first outpatient appointment. Of these 18,661 were waiting in excess of the ministerial target of nine weeks, and over a third (6,986 people) were waiting more than one year.

The HSC Board has subsequently advised that of March 2018 there were 24,095 people waiting for their first ophthalmology outpatient appointment. Of these, 19,424 were waiting in excess of the ministerial target nine weeks and almost half (10,159 people) were waiting more than one year for first appointment.

The Review Team was told that as part of elective care reform for ophthalmology, the HSC Board will be exploring opportunities for waiting list validation. In other specialties, this has resulted in a reduced number of patients waiting and in a refinement of waiting lists. The HSC Board has advised it is now commencing validation of waiting lists for eyecare services. This was seen by the Review Team as a positive and very necessary action.

While the Review Team welcomed plans for waiting list validation, it recommends that the DoH in conjunction with the HSC Board and PHA, exercises its responsibility for patient safety and increases its focus on the current waiting list for eyecare services, particularly the excessive waiting times for a first and further follow up outpatient appointments.

The Review Team was concerned that patients may be coming to harm as a result of delays in new and review appointments within secondary care (for a full range of eye conditions including wet age-related macular degeneration, glaucoma and diabetic retinopathy). While there was anecdotal evidence from optometrists and ophthalmologists to support this, there is no formal adverse incident data available on this group of patients currently waiting to be reviewed. Research would show that ophthalmology patients elsewhere in the United Kingdom are suffering preventable harm due to health service initiated delay leading to permanently reduced vision[13].

The Review Team explored the reasons why optometrists were not reporting potential sight loss for their patients, due to long waiting lists and delay in treatment, as an adverse incident. The Review Team notes that in the HSC Board Optometry Handbook (June 2016),[14] there is a section outlining the requirement to report adverse incidents to the HSC Board. This guidance defines an adverse incident and advises that adverse incident recognition and reporting is a crucial element of a robust clinical governance system. The guidance provides a method for practitioners to report incidents which occur within HSC services, even if not directly related to their own practice. The Review Team considers delays in accessing secondary care, delayed review appointments and the potential detrimental effects of excessive waiting times on patients' vision as reportable adverse incidents.

Adverse incident reports received by the Integrated Care Directorate within the HSC Board allow for trend analysis of incidents with the aim of identifying recurrent problems and patient safety issues. When the Review Team asked optometrists why they were not reporting delays as incidents, it became clear that they did not feel they had a requirement to do so, other than when the harm or potential harm was as a direct result of the care they had provided to individual patients.

The Review Team recommends that the HSC Board should ensure that there is a greater understanding and awareness of adverse incident recognition and reporting within primary care optometry services. The HSC Board also needs to ensure that it utilises adverse incident reporting to help measure the risk associated with growing waiting lists, excessive waiting times and delayed treatments.

The Review Team recommends that the guidance outlined in the HSC Board Optometry Handbook (June 2016)[15] is reassessed, reissued and fully implemented. The HSC Board should assure itself that this guidance is robustly implemented and that trend analysis of incidents is regularly undertaken.

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[13] http://www.nature.com/eye/journal/v31/n5/full/eye20171a.html
[14] http://www.hscbusiness.hscni.net/pdf/Optometry_Handbook_June_2016_(updated).pdf
[15] http://www.hscbusiness.hscni.net/pdf/Optometry_Handbook_June_2016_(updated).pdf

Recommendation 2	Priority 1
a) The DoH in conjunction with the HSC Board and PHA should address the current waiting list for eyecare services, particularly the excessive waiting times for first and follow up outpatient appointments. b) The Eyecare Network (successor to DEP) must make reduction in waiting times for new and follow-up appointments across eyecare services one of its main priorities. An initial plan to reduce waiting lists, using resources available in both primary and secondary care, must be produced within 6 months. c) The HSC Board should immediately reassess, reissue and fully implement guidance in relation to the identification and reporting of adverse patient incidents outlined in its Optometry Handbook (June 2016)[16] for primary care optometry practitioners. d) The HSC Board should assure itself that this guidance is robustly implemented and that trend analysis of incidents is regularly undertaken, to help to measure the risk associated with growing waiting lists, excessive waiting times and delayed treatments.	

One of the key factors that will underpin any initiative to reduce waiting lists is the potential to move services safely and effectively from secondary care into primary care. The Review Team considers that it is vitally important that work undertaken to date to move services is consolidated and forms the basis of future service development.

3.3 Integrated Eyecare Models & Pathways

Ophthalmology is a high demand specialty, typically accounting for approximately 10 per cent of all annual outpatient appointments (regionally and nationally) and for 7.1 per cent of all consultant led appointments annually. In the Northern Ireland context, this demand is in excess of 100,000 acute care appointments annually[17].

A primary driver for the development of the DEP Strategy in Northern Ireland was an identified need to increase services that are currently provided by primary care providers in partnership with secondary care clinicians, in order to reduce the current pressure on secondary care services.

Objective 6a of the DEP Strategy aimed to develop integrated care pathways for long term conditions to include glaucoma, cataract and macular degeneration. Task Group 2 of the DEP project had pathway development as one of its key objectives.

[16] http://www.hscbusiness.hscni.net/pdf/Optometry_Handbook_June_2016_(updated).pdf
[17] http://echonorthernireland.co.uk/echo-networks/ophthalmology/

Local Enhanced Services for Ocular Hypertension and Glaucoma Referral

Glaucoma is an eye condition in which the optic nerve which carries signals from the eye to the brain is damaged. Unfortunately glaucoma causes few, if any, symptoms until very late on in the condition.

Glaucoma cannot be cured or reversed but treatment can halt or slow down its progression. Optometrists can perform a vital function by looking for evidence of glaucoma, or any risk factors for the development of glaucoma, during routine sight tests. One of the risk factors for developing glaucoma is raised pressure in the eye and lowering this pressure is the mainstay of treatment. Whilst high eye pressure is not found in all glaucoma sufferers, measurement of the eye pressure is one of the important tests performed during a routine sight test. Due to a range of factors this eye pressure test is not always accurate; falsely high readings (false positives) can occur, causing unneeded referrals to secondary care.

To meet the DEP Strategy objective, the glaucoma/ocular hypertension care pathway was reviewed and the HSC Board developed and delivered a primary care optometry LES across Northern Ireland. This LES, established in December 2013 was promoted and facilitated by the DEP project. Known as LES I, it funds primary care optometrists to carry out a repeat intraocular pressure test to confirm the need for referral to secondary care. The aim of this LES is therefore to enable optometrists to repeat pressure measurements, thereby reducing false positive referrals for ocular hypertension to hospital services (based on eye pressure alone). This has a knock-on benefit of reducing patient anxiety and increasing capacity within hospital glaucoma clinics.

In order to deliver LES I, all optometrists in Northern Ireland who elected to participate were required to (i) complete and pass an approved ocular hypertension/ glaucoma training course provided in partnership with Ulster University and (ii) have the approved applanation tonometry equipment (which facilitates a more precise way of measuring eye pressure).

The HSC Board reports that LES I has been very successful, contributing to a marked reduction in unnecessary referrals from primary to secondary care. In 2015, the HSC Board reported that following the introduction of LES I in December 2013, 65 per cent of patients (2,398) were managed by optometrists in primary care and were not referred to secondary care following repeated intraocular pressure measurement.

In June 2016, a further LES to support enhanced case finding for glaucoma, suspected glaucoma or ocular hypertension in primary care, known as LES II was introduced by the HSC Board. Again the LES was facilitated by Task Group 2 of DEP.

LES II enabled primary care optometrists to conduct or repeat further diagnostic tests to identify glaucoma or ocular hypertension (such as visual fields and dilated indirect ophthalmoscopy). Uptake for LES II has not been as high as for LES I. Currently 83 primary care practitioners hold the College of Optometrists' Professional Certificate in Glaucoma to allow them to deliver LES II.

While there have been improvements in referral processes following the introduction of LES II, these have not been as marked as the results seen with implementation of LES I. This is most likely due to the smaller number of participating primary care optometrists. The Review Team was told that there remains some resistance among secondary care ophthalmologists to optometrists' case finding and monitoring ocular hypertension (in a context where the individual patient may not ever be seen by a secondary care consultant). The Review Team considered that this was a likely barrier to the further implementation of LES II across Health and Social Care.

The Review Team considers that the DEP project has contributed to the development of a pathway for referral of glaucoma patients, with an associated shift in emphasis to primary care. The Review Team considers that the Royal College of Ophthalmologists Glaucoma Commissioning Guidance[18] based on NICE (CG85)[19] Glaucoma Guidelines, on behalf of the whole optical sector, may provide useful information to support the future monitoring of ocular hypertension by optometrists in primary care. This commissioning guidance will be helpful as it is based on NICE guidance and sets out NICE compliant recommendations for qualifications and competencies for health care professionals involved in glaucoma care pathways.

Rapid Access Referral Protocol for Wet Age-Related Macular Degeneration

Age-related macular degeneration affects a tiny part of the retina at the back of the eye, called the macula. It causes changes to the macula, which can lead to reduced central vision; however it doesn't cause pain, and may not lead to the total loss of sight. Wet age-related macular degeneration needs to be treated within two weeks of initial identification. Failure to assess and treat patients within this short time frame can lead to rapid and marked irreversible sight loss.

In line with Objective 6a of the DEP Strategy, Task Group 2 of the DEP project has overseen the development of a new regional rapid-access referral protocol, involving both primary and secondary care, for the macular service (including wet age-related macular degeneration, retinal vein occlusion and diabetic macular oedema).

The rapid access referral service not only gets the patient to the correct clinic in a timely manner (assisting triage and reducing risk), it also aids the decision-making of the referring optometrist, prompting relevant history and symptom-taking. The referral process has been further streamlined and improved with the introduction of electronic referral, which in turn facilitates potential for e-Triage and referral for advice. Early testing and piloting of the e-Triage function have demonstrated the potential to reduce false positive referrals.

A regionally-agreed rapid access referral protocol for the macular service has been in use since May 2016, and is hosted (with appropriate guidance to aid clinical decision-making) on the Clinical Communications Gateway (CCG) within the Northern Ireland Electronic Care Record (NIECR). The aim of the new regionally agreed rapid-access referral protocol is to ensure that signs and symptoms of suspected wet macular degeneration are accurately identified and recorded.

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[18] https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2010_PROF_099_Letter-to-PCTs-re.-Goldman.pdf
[19] https://www.nice.org.uk/guidance/CG85

The protocol allows referring optometrists to involve the patient more fully in decision-making and to expedite any referral to the most appropriate clinical setting, along with the patients clinically-significant information (including scans/images where appropriate). The referral protocol also facilitates a ‘referral-for-advice’ function.

In relation to the work on integrated eyecare models and pathways, the Review Team particularly noted the success of the local enhanced service for glaucoma/ocular hypertension (LES I). This should continue to embed across the region with all primary care optometrists encouraged to participate, to facilitate a continued reduction in referrals to secondary care. The Review Team considers that work should also continue to progress the rapid access pathway for macular degeneration.

The Review Team also welcomed the introduction of a local enhanced service for glaucoma and ocular hypertension enhanced case finding in primary care (LES II). The Review Team has accepted that the uptake for LES II among optometrists in primary care has not been as high as with LES I and that the improvements in referral processes have not been as marked as the those seen with LES I; however the Review Team still considers that work to support the further spread and scale of LES II should continue.

The Review Team considers that the DEP project has been instrumental in the development of these important pathways and that further pathway development should be progressed by the regional Eyecare Network (successor to DEP).

Recommendation 3	**Priority 2**
a) The Eyecare Network (successor to DEP) should continue to work with the DoH to prioritise and consolidate recently developed models and pathways; the network should lead the development of further integrated eyecare models and pathways across Northern Ireland. b) Further development of eyecare models and pathways should, in partnership with secondary care clinicians, focus on increasing service provision by primary care providers.	

Southern Primary Eyecare Assessment and Referral Service

In addition to long term or chronic ophthalmic conditions, patients who have sudden onset or acute eye conditions contribute to the demand for unscheduled or emergency eyecare. Although often painful and/or concerning, many of these conditions are more minor in nature and could be managed safely by optometrists in primary care.

In response to increasing demands on eye casualty in the Southern HSC Trust area, the Southern Area Local Commissioning Group (LCG) developed a pathway for the diagnosis and management of acute eye conditions. This pathway allows for a patient who develops an acute, sudden onset eye problem to be seen promptly by a primary care optometrist, rather than by a General Medical Practitioner or at eye casualty. The primary care optometrist initially assesses whether the condition is of a minor nature which could be safely managed or a more serious and potentially sight threatening disease process requiring urgent specialist attention.

In 2014, the LCG funded a one year SPEARS pilot scheme in the Armagh/ Dungannon area; this was delivered by 12 optometry practices covering a local population of 12,500 people. The total cost of the pilot scheme was £46,160.

During the pilot, almost 900 patients accessed SPEARS. The evaluation of the pilot compared the treatment that had been provided in primary care against what would have been expected to have been provided in secondary care. Results showed that 81.5 per cent of these patients were managed by primary care optometrists, consistent with how they would have been managed and treated in secondary care. The HSC Board has published a detailed evaluation of SPEARS[20].

In relation to patient experience, 87 per cent of patients reported that they were "extremely satisfied" with the service they had received through SPEARS.

As part of the evaluation process, a Consultant Ophthalmologist audited clinical records, to assess the actions taken by the SPEARS optometrist and to determine if any patients had subsequently required secondary care input. In a sample of 256 patient records audited, only 3 (1.17 per cent) patients required a further intervention in secondary care, demonstrating the effectiveness of the service provided.

The SPEARS evaluation examined the numbers of referrals to ophthalmology services during 2014 (before the pilot was established) and 2015 (when the pilot was running). Regionally, referrals from primary to secondary eyecare services increased by 5 per cent while in the Armagh/Dungannon locality referrals fell by 9 per cent, which equates to 224 outpatient appointments. It follows that regional scale and spread of the SPEARS service has the potential to considerably reduce demand on secondary care services.

Feedback from ophthalmologists in secondary care described SPEARS as very successful. They identified acute eye injury as one area where capacity could be freed up in secondary care by the regional spread and scale of SPEARS. Feedback from The British Medical Association[21] Local Medical Committee for the Southern HSC Trust area, which represents local General Medical Practitioners, was also positive from the general practitioner perspective.

In 2016/17, following evaluation of the pilot, the Southern LCG funded an extension of the service across the entire Southern HSC Trust area. The service is now delivered by 41 optometry practices, serving a population of 40,800 people.

[20] http://www.hscbusiness.hscni.net/pdf/SPEARS_Evaluation_Report_March_2016.pdf
[21] The British Medical Association (BMA) is the trade union and professional body for doctors in the UK.

Information about the service has been shared with General Medical Practitioners and community pharmacists and with the wider public.

Following on from the development of SPEARS, during 2016 the Belfast HSC Trust developed guidance to assist primary care optometrists and General Medical Practitioners, to determine the level of urgency which should be assigned to patients with acute eye presentation/ophthalmic eye emergencies. This guidance was received and accepted by the DEP project, recommended for regional use and subsequently issued by the HSC Board to all optometry practices and to General Medical Practitioners. This has complemented SPEARS by assisting practitioners with their decision making regarding acute eye conditions.

The Review Team was told that the DEP project planned to facilitate further spread and scale of the SPEARS service across Northern Ireland, to provide a streamlined acute care pathway in the context of safe and appropriate local eyecare provision.

The Review Team acknowledges that the DEP project was a key driver for the development and pilot of SPEARS, which was itself modelled on similar successful services in other parts of the United Kingdom. The Review Team considers that evidence from evaluation of the local pilot scheme, in terms of the safety and effectiveness of the service and its potential to reduce the need for attendance at secondary care services, supports the case for its further spread and scale across Northern Ireland. The Review Team understands that work is ongoing to secure funding from the DoH to support this spread.

Recommendation 4	**Priority 1**
The Eyecare Network (successor to DEP) should continue to work with the DoH on the spread and scale of the SPEARS (Southern Primary Eyecare Assessment and Referral Service) scheme to other areas of Health and Social Care across Northern Ireland.	

Community Based Cataract Care

While there has been progress with the spread and scale of refreshed cataract referral processes (with accompanying training and guidance for optometrists), the Review Team considers that there has been less progress in relation to utilising primary care optometrists in the post-operative review of patients who have had cataract surgery.

If patients at lower risk of sight threatening problems could be managed by optometrists in primary care, this could free up appointments in secondary care services, to ensure that those at higher risk of sight loss are seen in a timely fashion by the appropriate service. The post-operative phase of the cataract pathway includes a clinical examination to check for or treat any postoperative complications, to assess visual outcomes and refractive status and to ascertain the patient’s satisfaction following cataract surgery.

In many cataract services around the United Kingdom, community optometrists are commissioned to deliver many of the postoperative phases of the cataract pathway[22].

Despite evidence demonstrating the success of similar schemes for community based cataract care across the United Kingdom[23], some stakeholders involved in the DEP project indicated that there is a perceived reluctance among ophthalmologists in secondary care to further develop a model which includes delivering post-operative review by primary care based optometrists, following cataract surgery.

Concerns were also voiced that shifting routine postoperative cataract care from secondary to primary care could impact negatively on the training of junior doctors.

The Review Team concluded that these concerns are appropriate and valid however they are surmountable by:

i. ensuring a proportion of routine cataract surgery patients are reviewed by junior doctors who have performed the surgery and
ii. maintaining appropriate feedback from community optometrists with regard to the refractive outcome of surgery. To ensure appropriate quality of care, post-operative cataract patients with significant ocular co-morbidities should continue to be reviewed within the secondary care setting.

The increased use of primary care optometrists is supported by the Ophthalmology Common Clinical Competency Framework, which states that optometrists working in the community are well qualified and well placed to assess post-operative eye health and visual acuity and are accustomed to using reporting processes to feed these findings back to the operating surgeon[24].

The Review Team considers that utilising primary care optometrists in the post-operative review of cataract patients with no significant ocular comorbidities should help to free up capacity within secondary care, and in turn help to reduce the long waiting times for new and follow up appointments in secondary care services.

The Review Team would emphasise that more work is needed to enhance clinical relationships and to build trust between primary care optometrists and ophthalmologists in secondary care. The Review Team would also stress that not all patients are suitable for treatment in primary care. The aim of every pathway should always be to ensure that all patients receive the right level of care provided by the most suitable clinician in the right location.

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[22] https://www.rcophth.ac.uk/wp-content/uploads/2015/12/Commissioning-Guide-Cataract-Surgery-February-2015.pdf
[23] https://www.rcophth.ac.uk/wp-content/uploads/2015/10/RCOphth-The-Way-Forward-Cataract-300117.pdf
[24] https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/

Recommendation 5	Priority 2
a) The Eyecare Network (successor to DEP) should prioritise the utilisation of core trained optometrists to develop and commission primary care based cataract services, particularly the post-operative care of patients who have had cataract surgery. b) Development of primary care based cataract services should ensure that all patients receive the right level of care provided by suitably trained clinicians in appropriate locations.	

Glaucoma Clinic

In June 2013, a new Glaucoma clinic was opened at the Shankill Wellbeing and Treatment Centre in Belfast. This “one stop” Glaucoma clinic is staffed by a multidisciplinary team including ophthalmologists, optometrists, nurses and a range of technical staff.

Prior to this, optometrists had to refer patients to a hospital-based Consultant Ophthalmologist as specialist equipment was required to detect and treat glaucoma. This community-based service, which is commissioned by the Belfast LCG and delivered by the Belfast HSC Trust provides patients with same-day diagnosis and treatment.

As part of the transformation plans of DEP Task Group 2, an initiative was developed to enable the glaucoma service to be partly delivered by primary care community optometrists with a special interest (COSIs). This development offered the possibility for ‘teach and treat’ clinical rotations whereby experienced community optometrists would further develop their skills by working alongside Consultant Ophthalmologists.

The Review Team was told that although initially this concept seemed to provide a unique opportunity, access to ‘teach and treat’ clinical rotations for primary care optometrists has not been fully realised. The Review Team considered this to be a missed opportunity not only to facilitate joint working between primary and secondary care, but also to further develop the skills of primary care optometrists and ultimately streamline glaucoma services for patients.

Ophthalmic Clinical Centres

Building on the successful model for glaucoma services, the DEP project has facilitated proposals to consolidate a number of Ophthalmology Outpatient Services, currently provided by the Belfast HSC Trust, in twelve centres across Northern Ireland, which currently do not carry the full range of diagnostic or multi-skills infrastructure, into three one stop services. The trust is proposing that these outpatient services in the Northern, Southern and South Eastern HSC Trust areas are brought together into three specialist Ophthalmic Clinical Centres.

These centres will be staffed by a multidisciplinary team including ophthalmologists and optometrists, nurse practitioners, general nurses and a full range of technical staff and will provide patients with with same-day diagnosis and treatment.

The new Ophthalmic Clinical Centre locations are:

- Northern Area; Health and Care Centre, Ballymena – opened April 2017
- Southern Area: Banbridge Polyclinic Site – in planning
- South Eastern Area: Downe Hospital Site – in planning

Consultant Ophthalmologists told us that they support the consolidation of Ophthalmology Outpatient Services into these three hubs. They agreed that this approach will lead to a reduction in the number of repeat appointments, ensuring that patients will be seen and have all necessary testing in one location. The strategic coordination role of DEP has shaped this initiative, with DEP Co-Chairs working closely with Local Commissioners and trusts to bring the initiative to fruition.

The Review Team considers the development of Ophthalmic Clinical Centres to be a positive step with advantages including the maximisation of resources, better care for patients as they have to visit one location only and a streamlined multidisciplinary approach.

Supporting People: The role of the Eye Clinic Liaison Officer

While not directly linked to the DEP project, the Review Team felt that the support provided by the Eye Clinic Liaison Officer (ECLO) service was worthy of note. In Northern Ireland, the ECLO service is available in eye clinics and, by referral, through optometric practices across the five trust areas. This service is funded by the HSC Board and commissioned from the Royal National Institute of Blind People (RNIB).

The Review Team considers that ECLOs are key personnel in helping patients to understand the impact of their diagnosis and in providing emotional and practical support for patients, including certification as sight impaired or severely sight impaired. ECLOs work closely with medical and nursing staff in eye clinics and with sensory teams in social services.

Being diagnosed with an eye condition can be difficult to come to terms with. We were told by the ECLOs that it can be an extremely confusing and uncertain time for patients and in many cases emotionally traumatic. Often patients can find dealing with the emotional and practical impact of changes to their sight to be overwhelming. Eye clinic staff and volunteers are often the first point of contact for people coping with sight loss and therefore have an important role in providing practical information, emotional support and signposting to other services.

The RNIB website reports that a survey of registered individuals revealed that after diagnosis, 92 per cent of blind and partially sighted people were not offered formal counselling by the eye clinic, either at the time of diagnosis or later.

Statistics show that nearly a quarter of blind and partially sighted people (23 per cent) leave the eye clinic not knowing, or unsure of, the name or nature of their eye condition[25].

RNIB considers that the appointment of an ECLO may be one of the most effective ways of providing emotional and practical support to patients in eye clinics. A recently published evaluation report of the impact of ECLOs: UK wide findings 2015-2016[26] summarises national figures, including Action for Blind People (England) and RNIB Cymru, Northern Ireland and Scotland. Results from this evaluation report included that:

- Patients reported increased emotional wellbeing as a result of support from ECLOs.
- Patients reported that their ECLO contact gave them time to discuss how they felt about their eye condition.
- After visiting the ECLO patients' understanding of the support available outside of the eye clinic was increased.

The Review Team also considered that ECLOs in trusts provide useful support for patients in understanding and dealing with their eye condition.

3.4 Training and Professional Development

The Review team was advised by the HSC Board that during 2015/16, training in the following care pathways was delivered:

- Acute Eye Pathway
- Glaucoma Pathway
- Cataract Pathway
- Macular Pathway
- Diabetic Eye Screening Pathway

In addition to this, Task Group 1 progressed Objective 10 of the DEP project which specifically includes "promotion of independent optometrists' prescribing, where appropriate to do so."

The rationale for increasing the number of independent prescribers among optometrists is that if the first point of contact for patients is an optometrist who is qualified to independently prescribe, this will potentially reduce the number of health professionals the patient may need to see to receive the necessary advice and treatment.

Optometrists undertaking a qualification in independent prescribing must complete a clinical practice placement within a secondary care service or

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[25] http://www.rnib.org.uk/ecloinformation

[26] https://www.rnib.org.uk/professionals/knowledge-and-research-hub/research-reports/early-reach-research/ECLO-impact-tool

specialist general practice, under the mentorship of a Consultant Ophthalmologist.

The clinical placement must commence within two years of completing a specialist therapeutics course. A final examination is then undertaken within two years of completing the clinical placement. Stakeholders participating in this review including education and primary care optometrists highlighted that it has been difficult to secure local clinical placements for optometrists undertaking independent prescribing training in Northern Ireland.

The Review Team considered that progress has been made in relation to the promotion of independent optometrist prescribing, with the registration of nine optometrists who can provide prescriptions in primary care. In addition, an agreed arrangement is in place for the Belfast and Western HSC Trusts to provide twelve, non-recurring clinical placements for optometrists, within a hospital setting. These placements are funded non-recurrently by DoH, and are a direct outcome of the work of DEP Task Group 1. This service development is managed by the HSC Board and promoted and facilitated by the DEP project. A waiting list for applicants is also maintained.

The Review Team supports this initiative to increase the number of prescribing optometrists, recognising that it has the potential to improve care for patients.

Project ECHO® (Extension for Community Healthcare Outcomes)

The ECHO® initiative uses teleconferencing technology to improve access to specialised care, through supporting and training primary care professionals remotely. This is done using a centralised hub of experts, in this case Consultant Ophthalmologists and Biomedical Scientists from the Belfast and Western HSC Trusts, and clinical academics from Queens University Belfast (QUB).

The aim of the optometry/ophthalmology ECHO® knowledge networks is to allow primary care optometrists a safe space to improve their knowledge, thus helping to improve their management of patients who present with suspected glaucoma, macular eye disease or an acute eye condition. Ultimately, by using telementoring and case sharing, ECHO® aims to enhance the knowledge, confidence and competence of primary care optometrists, enabling care to safely and appropriately transfer from secondary care into primary care settings.

In a pilot undertaken in 2015/16, 21 primary care optometrists from across Northern Ireland took part in 12 ECHO® sessions to gain additional knowledge, skill and confidence in the diagnosis and management of patients with long term ophthalmic conditions.

Participants involved in the evaluation of the ECHO® project described the project as having:

- an education platform that enhanced their clinical knowledge and skills;
- provided an environment that facilitated the development of interdisciplinary relationships and communication;

- optimised the care they delivered to their patients and increased their confidence in making appropriate referrals;
- created a safe learning environment for participants.

The evaluation report[27] on this ECHO® project indicated that the pilot programme had facilitated a statistically significant improvement in both self-efficacy and demonstrable skillsets and in recognition and monitoring risk-stratified glaucoma and macular patients among the primary care optometrists who participated.

The Review Team was supportive of the ECHO® project, recognising that it has been successful in enabling effective and productive engagement between primary care optometrists and secondary care ophthalmologists and in providing an effective tool to support key service developments. The initiative has been successful in building relationships and trust between professionals and it has helped to reduce anxieties in relation to the transfer of care from secondary to primary care settings.

The Review Team considers that ECHO® may continue to assist in the development of future models of care, by developing the skills of primary care optometrists to enable them to widen the scope of care they provide. The Review Team has also been assured by DEP project representatives that ECHO® will be a sustainable option for the future as potential time and capacity challenges for the consultant ophthalmologists who provide the training have been addressed.

Recommendation 6	**Priority 3**
The Eyecare Network (successor to DEP) should continue to explore the use of Project ECHO® and other potential technical solutions as a learning tool to improve skills, build relationships and facilitate the safe transfer of care from secondary to primary care settings.	

3.5 Information, Communication & Technology

Objective 11 of the DEP Strategy identified that ICT developments would be required to improve referral, communication, payment and probity systems. It further identified that telemedicine links have the capacity to improve the quality and efficiency of service provision.

The Review Team notes and supports the subsequent developments in information, communication and technology across Health and Social care in Northern Ireland, including the establishment of the CCG. This work, led by the HSC Board, as part of the e-Health and Care Strategy, in conjunction with the Business Services Organisation (BSO) and HSC Trusts should assist in the development of a number of areas addressed in previous paragraphs of this report.

[27] http://echonorthernireland.co.uk/wordpress/wp-content/uploads/2016/05/ECHO-NI-Evaluation-Report-2015-2016.pdf

Electronic Referrals

Annually, there are in excess of 30,000 new referrals from primary care to secondary care ophthalmology services. In 2016, in an effort to streamline this process the HSC Board commissioned work to facilitate electronic referral from primary to secondary care (e-Referral) by community optometrists. As a result, The Clinical Communications Gateway has been established, which is the national system in health and social care for the electronic exchange of information – referrals between primary and secondary care. The Review Team was informed that electronic referral enables images of diagnostic tests from primary care to be viewed in the hospital, hence reducing duplication and speeding up diagnosis. At the time of this review, 80 per cent of all optometrists (218 in total) had been IT enabled and the first cohort of optometry e-Referrers had started to use e-Referral.

The Review Team considers that e-Referral has the potential to improve referral processes, helping to manage demand and improve patient safety. As the e-Referral system becomes embedded, it will facilitate the HSC Board's access to more robust data on referral patterns by condition. The Review Team considers that in the longer term, this information must be used to improve the commissioning and provision of eyecare services in Northern Ireland.

When fully established, the e-Referral system will support capability for e-Triage through the NIECR and it will provide a communication channel for advice from secondary care providers to primary care providers.

The Review Team welcomes the establishment of electronic referral (e-Referral) directly from primary to secondary care services. The Review Team notes the further potential of the system to provide e-Triage and to provide a more robust communication channel for provision of advice by secondary care providers on the management of patients in primary care.

Electronic Records

The Review Team was advised that future integration of general ophthalmic service referrals into the Clinical Communications Gateway and the planned access for general ophthalmic service practitioners to the NIECR will enhance system-wide integration and support better coordination between primary care and secondary care services. There was unanimous support for this development from all members of the Review Team. The HSC Board advised that the timescale for completion of this integration is Quarter 2 2017/18.

Recommendation 7	**Priority 2**
The Eyecare Network (successor to DEP) should continue to work, in collaboration with HSC Board, to promote access to the Clinical Communications Gateway.	

Northern Ireland Sight Test Survey

In 2014, Task Group 1 of the DEP project worked with the DoH to deliver a Northern Ireland Sight Test and Ophthalmic Public Health Survey[28]. This survey included data capture on elements of ophthalmic public health, with the aim of providing baseline information. This baseline information would be used to inform commissioning, planning and delivery of eyecare services across Health and Social Care. The findings from the survey would also support the work of DEP project.

The survey records information on demographics of people having sight tests, public health information such as smoking status, outcome of the sight test and any onward referral made following each person's test. For the 2014 survey a 34.1 per cent response rate was reported; not all optometry practices participated in the survey.

The Review Team considers that the 2014 sight test survey, has not delivered tangible outputs. The survey, as designed, provided only transactional data e.g. numbers of sight tests completed and numbers of spectacles provided. Completion was not mandatory and so uptake was low, and the resulting output did not therefore provide a full picture of services across Northern Ireland. It was also not clear to the Review Team what actions if any had been taken following analysis of the survey returns.

The Review Team understands that the DEP project is again working with the DoH to develop a further enhanced survey. This survey is designed to ask a wider range of questions relating to areas such as referral pathway and method, equipment availability and information related to co-morbid illnesses.

The HSC Board has advised that all data from the second sight test survey will be analysed and the information gathered will be used to help inform the HSC Board's future planning for optometry services.

3.6 Patient and Public Involvement

Representation from service users and voluntary agencies on the DEP project was designed to ensure that people who access services had an opportunity to input into the planning and development of these services. That people should have a stronger voice in decisions about their health and care, and that services should better reflect their needs and preferences, was seen as a key requirement for the DEP project.

The Review Team did note that the DEP project was proactive in ensuring some involvement of service users, patients and carers by providing opportunities for feedback.

These included the SPEARS evaluation and the local enhanced service for glaucoma enhanced case finding in primary care (known as LES II and detailed in section 3.3 of this report).

[28] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/ni-sts-2014.pdf

The Review Team also welcomed the collaboration between the DEP project and the 10,000 Voices initiative within the PHA, which was used to obtain feedback from service users, families and carers on their experience of eyecare services. It was noted however that that this initiative was focused on those patients receiving services within secondary care settings. In the future, initiatives should be considered to engage patients receiving treatment and care in primary care settings. Future initiatives should, importantly, also capture experiences of those waiting to access services (i.e. those on waiting lists).

The Review Team recognised there was some input from voluntary agencies on various Task Groups. However, this level of input would not amount to fully involving people in planning and developing eyecare services through the DEP project.

3.7 Health Promotion

Raising awareness of eye health is essential to promote good eye health. The Review Team was told of a number of initiatives, attributed to Task Group 5 of the DEP project, which had the aim of promoting good eye health and preventing eye disease. These included:

- The development of a video resource[29], uploaded to the HSC Board website, demonstrating what is involved in a sight test;
- A press release from the PHA in support of World Diabetes Day included content on eye health[30];
- Occupational eye injury posters developed for employers and employees, addressing the prevention of occupational eye injury in the workplace[31]; publications were distributed to employers in manufacturing, construction, agriculture and small business and are available for download from the PHA website;
- Orthoptic representatives from the PHA and school nursing have worked collaboratively, to provide a vision screening programme and eyecare services in special schools;
- Links have been established with key stakeholder groups and networks involved in falls pathways and a revised risk assessment toolkit for vision and falls is being piloted within the South Eastern HSC Trust;
- Brief intervention smoking cessation training sessions have been delivered for optometrists working in primary care settings.

The Review Team commends this activity for the promotion of eye health and the associated campaigns to raise awareness, and noted the dynamic ‘can do’ approach to the work which has been undertaken. As the work of the DEP project comes to an end, the Review Team considers that this valuable health promotion work should continue.

[29] http://www.hscboard.hscni.net/our-work/integrated-care/ophthalmic-services/
[30] http://www.publichealth.hscni.net/news/world-diabetes-day-%E2%80%93-knows-signs-reduce-your-risk
[31] http://www.publichealth.hscni.net/publications/protect-your-eyes

In the short term, the Review Team recognises that it may be difficult to demonstrate tangible outcomes of health promotion initiatives and in view of this it is recommended that in the medium and longer term a robust evaluation of the various initiatives should be undertaken. The Review Team considers that future public health evaluations and initiatives should be led by the PHA in collaboration with key partner organisations and stakeholder groups.

The Review Team considers that health promotion work in relation to eye heath should be seen as a priority and would benefit from inclusion in the PHA annual work plan.

Recommendation 8	**Priority 2**
a) The promotion of eye heath should continue to be seen as a priority and should be led by the PHA in collaboration with key partner organisations and stakeholder groups. b) It is recommended that an evaluation of the various health promotion initiatives progressed by the DEP project should be undertaken in the medium and longer term.	

3.8 Legislative Framework

The General Optical Council is the professional regulator for the optical professions. The Council's purpose is to protect the public by promoting high standards of education, performance and conduct amongst opticians. The Council currently register around 29,000 optometrists, dispensing opticians, student opticians and optical businesses across the United Kingdom. All optometrists in Northern Ireland must be registered and are professionally regulated by the General Optical Council as individual practitioners.

Currently in Northern Ireland, all general ophthalmic service providers are governed by and have to work within the General Ophthalmic Services Regulations (Northern Ireland) 2007. These regulations are overseen by the HSC Board.

Owners of optometry practices in primary care are independent contractors who are contracted by the HSC Board to deliver general ophthalmic services which are defined by the General Ophthalmic Service Regulations. Practice owners are responsible to the HSC Board for any breaches of regulations within their practices. All other optometrists and dispensing opticians employed in optometry practices are not listed on the HSC Board ophthalmic list as contractors and so, although they are professionally accountable to the General Ophthalmic Council, they are not directly accountable to the HSC Board.

At present, while there is no optometry performer's list[32] in Northern Ireland, there are arrangements through terms of service in place for the delivery of general ophthalmic service sight tests. Primary legislation is needed to allow the HSC Board to develop and maintain an extended listing system, thus ensuring that all practitioners are accountable to the HSC Board (for their own practice) rather than just the contractor owner of an optometry practice. This is particularly important as optometrists in primary care become more involved in delivery of enhanced services for and to their patients.

Task Group 1 of the DEP project, led by the DoH, is responsible for workforce and legislative issues. Task Group 1 has examined the regulatory frameworks which exist in England, Scotland and Wales, in order to determine the best regulatory framework for Northern Ireland.

The Review team considered that it was important that a robust regulatory framework for individual optometrists was in place and that regulatory powers were fit for purpose in primary care optometry services. This was especially important given the strategic direction of DEP, which is to achieve the best balance between the use of primary care optometry services and secondary care ophthalmic services by placing more emphasis on treatment in primary care.

In 2015/16, DEP Task Group 1 sent draft amending regulations to the DoH for consultation; however full consultation on the amendments has been delayed due to the uncertainty in knowing where, following planned service reform, the responsibility and accountability for general ophthalmic services provision will sit. This delay may result in the legislative framework in Northern Ireland falling out of step with other parts of the United Kingdom, where national performer's lists are in place.

In relation to the overarching governance of all general ophthalmic service providers in Northern Ireland, the Review Team considers that it is important that the DoH continues to work towards amending the General Ophthalmic Services Regulations (Northern Ireland) 2007, to extend the regulations to all practising ophthalmic practitioners.

Performance listing would provide an extra layer of reassurance for the public and practice owners, who currently have individual responsibility, that all practising optometrists are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks including Access Northern Ireland.

Recommendation 9	**Priority 2**
The DoH should continue to work to amend the General Ophthalmic Services Regulations (Northern Ireland) 2007 to extend the regulations to all practising ophthalmic practitioners in Northern Ireland.	

[32] A performer's list is a list of practitioners managed by commissioners. All practitioners have to be suitably qualified and trained to remain on the performer's list which provides commissioners and the general public with assurance as to the suitability of practitioners on the list. No practitioner may provide services if not on the performer's list.

Section 4: Conclusions and Summary of Recommendations

4.1 Conclusions

In relation to the implementation process for the DEP Strategy the Review Team mainly viewed this process as being well structured and well managed. Regular updates were provided to the Project Board from each of the Task Groups and the Review Team saw evidence of robust recording of discussions and of decisions taken.

Stakeholders raised concerns with the Review Team regarding the slow pace of progress including some reservations about the complicated structures, the number of groups involved and a lack of clinical engagement with DEP project teams. The Review Team agreed that the structures were perhaps too complicated and were concerned by the lack of clinical input from both optometrists and ophthalmologists. General Medical Practitioner (GP) input was limited due to work commitments.

When the achievements of the DEP project were cross referenced with the original four overarching aims of the 2012 DEP Strategy[33] the Review Team concluded that the work undertaken, which had provided added value in a number of areas, had in some part failed to fully deliver against the original aims of the DEP Strategy. The Review Team considered that the increasing number of patients waiting for ophthalmic outpatient appointments meant that the DEP project had not achieved the overarching aim of the identification of potential sight-threatening problems at a much earlier stage.

In March 2017, figures indicate that there were 24,460 people waiting for a first outpatient appointment. Of these, 18,661 were waiting in excess of the ministerial target of nine weeks, and over a third (6,986 people) were waiting more than one year. In updated data for March 2018, this figure had risen to 24,095 people waiting for their first ophthalmology outpatient appointment. Of these, 19,424 were waiting in excess of the ministerial target nine weeks, and almost half of those (10,159 people) were waiting more than one year for first appointment.

As waiting lists continue to rise, the Review Team was concerned that patients may be coming to harm as a result of delays in new and review appointments within secondary care. The Review Team considers that, while the HSC Board is required to oversee the management of waiting lists, the DoH, in conjunction with the HSC Board and PHA, must exercise its overall accountability for patient safety by increasing their focus on waiting times, particularly the excessive waiting times for a first and further follow up outpatient appointments. The newly established Eyecare Network (successor to DEP) should make reduction of waiting times a priority.

[33] Developing Eyecare Partnerships - Improving the Commissioning and Provision of Eyecare Services in Northern Ireland - http://www.hscbusiness.hscni.net/pdf/DEVELOPING_EYECARE_PARTNERSHIPS_2012(1).pdf

As well as assessing the implementation process, the Review Team also assessed the achievements of the various strands of the DEP project, the changes made to service delivery and the resulting improvements for service users. In particular the Review Team welcomes and fully supports the work that has already been carried out in development of two LES's to improve care for patients with suspected ocular hypertension or glaucoma.

The Review Team further supports the regional spread and scale of the Southern Primary Eyecare Assessment and Referral Service (SPEARS) which will lessen pressure on secondary care services in eye casualty.

The Review Team commends the work that has been carried out in the development of cataract and macular degeneration pathways; however the Review Team considers that further work needs to be done in the development of primary care based cataract enhanced services, particularly in relation to post-operative care. Better links between primary and secondary care, established as a result of the DEP project, will be essential in progressing this work into the future.

The Review Team considers that the DEP project has supported the HSC Board in providing a coordinated framework for the commissioning of new approaches to the delivery of eyecare services. The DEP project has also been instrumental in developing and supporting improved dialogue between primary care optometrists and ophthalmologists in secondary care.

PPI was to be integral to the work of the DEP project. The Review Team recognised there was some input from voluntary agencies on various Task Groups. However, this level of input would not amount to fully involving people in planning and developing eyecare services through the DEP project.

The Review Team did however note that the DEP project had been proactive in involving service users in the SPEARS evaluation, the 10,000 voices project and in feedback in relation to LES II (glaucoma and ocular hypertension enhanced case finding).

The Review Team commends activity in relation to the promotion of eye health and the associated campaigns to raise awareness and noted the dynamic 'can do' approach to the work undertaken. As the work of the DEP project comes to an end, the Review Team considers that this valuable health promotion work should continue. The Review Team considers that work addressing eye heath should be seen as a priority and would benefit from inclusion in the PHA annual work plan.

The Review Team also supports the developments in relation to the establishment of the Clinical Communications Gateway which have facilitated electronic referral from primary to secondary care.

The Review Team considers that there have been a number of good developments which have been supported and facilitated by the DEP project but considers that it is important not to lose momentum. These developments must be consolidated into the future to ensure that patients receive the right eyecare, delivered by an appropriate clinician in an appropriate location.

The Review Team considers that following the standing down of the DEP project an Eyecare Network (successor to DEP) should be established with more clinical input and with a greater focus on implementation.

4.2 Summary of Recommendations

The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Recommendation 1 **Priority 2**

a) The current DEP implementation project structure should be stood down. An Eyecare Network (successor to DEP) sponsored by DoH and hosted by the HSC Board should be established to continue work in developing eyecare services.

b) The Eyecare Network (successor to DEP) should focus on the continued evaluation, spread and scale, refinement and delivery of integrated eyecare services across Northern Ireland.

c) Increased clinical input and a stronger clinical focus are required for the Eyecare Network's (successor to DEP) work programme going forward.

Recommendation 2 **Priority 1**

a) The DoH in conjunction with the HSC Board and PHA should address the current waiting list for eyecare services, particularly the excessive waiting times for first and follow up outpatient appointments.

b) The Eyecare Network (successor to DEP) must make reduction in waiting times for new and follow-up appointments across eyecare services one of its main priorities. An initial plan to reduce waiting lists, using resources available in both primary and secondary care, must be produced within 6 months.

c) The HSC Board should immediately reassess, reissue and fully implement guidance in relation to the identification and reporting of adverse patient incidents outlined in its Optometry Handbook (June 2016)[34] for primary care optometry practitioners.

d) The HSC Board should assure itself that this guidance is robustly implemented and that trend analysis of incidents is regularly undertaken, to help to measure the risk associated with growing waiting lists, excessive waiting times and delayed treatments.

[34] http://www.hscbusiness.hscni.net/pdf/Optometry_Handbook_June_2016_(updated).pdf

Recommendation 3 **Priority 2**

a) The Eyecare Network (successor to DEP) should continue to work with the DoH to prioritise and consolidate recently developed models and pathways; the network should lead the development of further integrated eyecare models and pathways across Northern Ireland.

b) Further development of eyecare models and pathways should, in partnership with secondary care clinicians, focus on increasing service provision by primary care providers.

Recommendation 4 **Priority 1**

The Eyecare Network (successor to DEP) should continue to work with the DoH on the spread and scale of the SPEARS (Southern Primary Eyecare Assessment and Referral Service) scheme to other areas of Health and Social Care across Northern Ireland.

Recommendation 5 **Priority 2**

a) The Eyecare Network (successor to DEP) should prioritise the utilisation of core trained optometrists to develop and commission primary care based cataract services, particularly the post-operative care of patients who have had cataract surgery.

b) Development of primary care based cataract services should ensure that all patients receive the right level of care provided by suitably trained clinicians in appropriate locations.

Recommendation 6 **Priority 3**

The Eyecare Network (successor to DEP) should continue to explore the use of Project ECHO® and other potential technical solutions as a learning tool to improve skills, build relationships and facilitate the safe transfer of care from secondary to primary care settings.

Recommendation 7 **Priority 2**

The Eyecare Network (successor to DEP) should continue to work, in collaboration with HSC Board, to promote access to the Clinical Communications Gateway.

Recommendation 8 **Priority 2**

a) The promotion of eye heath should continue to be seen as a priority and should be led by the PHA in collaboration with key partner organisations and stakeholder groups.

b) It is recommended that an evaluation of the various health promotion initiatives progressed by the DEP project should be undertaken in the medium and longer term.

Recommendation 9 **Priority 2**

The DoH should continue to work to amend the General Ophthalmic Services Regulations (Northern Ireland) 2007 to extend the regulations to all practising ophthalmic practitioners in Northern Ireland.

Appendix 1: Eye Disease in Northern Ireland

Eyecare in Northern Ireland[35] is currently delivered at primary, community and secondary care level, with a range of health care providers engaged in delivery. These health care providers include groups specifically trained in eyecare:

- Optometrists
- Dispensing Opticians
- Ophthalmologists
- Orthoptists
- Ophthalmic Nurses

The majority of optometrists, and the small number of dispensing opticians, work either as independent contractors delivering general ophthalmic services, or assisting in the provision of general ophthalmic services. This group can also be termed primary care or 'high street' optometric providers. In addition to this, General Medical Practitioners and high street pharmacists offer treatment, advice and referral in relation to eye problems.

The main provision of treatment for eye disease is in the secondary care sector within hospital departments, where teams led by Consultant Ophthalmologists deliver ophthalmic care covering many areas, including urgent eyecare, cataract, glaucoma, macular degeneration, amblyopia in children as well as a wide range of other eye conditions.

General Ophthalmic Services

General ophthalmic services are commissioned by the HSC Board and delivered by optometrists contracted to deliver general ophthalmic services; the contract is defined by the 2007 (and amended) Health & Personal Social Services statutory rules (General Ophthalmic Services Regulations (Northern Ireland) 2007)[36], and the associated schedules, including Schedule I: Terms of Service.

The 274 independent contractors are further assisted in the provision of general ophthalmic services by a number of optometrists and dispensing opticians registered with the regulator (the General Optical Council), but not themselves listed on the ophthalmic list as contractors. There are currently in the region of 500 optometrists and dispensing opticians engaged in the provision of general ophthalmic services.

In 2016/17 the core annual budget for the provision of general ophthalmic services was £23.486m. In addition there is a small, largely recurrent primary care ophthalmic budget (for Local Enhanced Services) of £0.375m. In 2016/17, this demand led budget was equal to the provision of approximately 425,000 HSC funded sight tests, and just over 200,000 vouchers towards the provision of optical appliances such as spectacles and contact lenses.

[35] narrative provided by HSC Board – profiling paper in January 2017
[36] http://www.fodo.com/downloads/gos/GOS%20Regulations-(northern-ireland)-2007.pdf

In primary care settings, extra commissioned services are mostly delivered through the mechanism of local enhanced services (LES). There are currently regional local enhanced services for:

- raised intraocular pressure repeat measures referral refinement: to reduce the numbers of false positive referrals for ocular hypertension (LES1);
- enhanced case finding: to provide a fully informed referral to be made to the hospital eye service for those patients with suspicious optic nerve appearance (LES2);
- a Southern Area Local Commissioning Group local enhanced service for the management of non-sight threatening acute eye presentations.

Future service modernisation will consider local enhanced service commissioned activity relating to pre and post-operative cataract review and risk stratified step down care for stable ocular hypertension and low risk glaucoma.

Hospital Eye Services

Ophthalmology services are commissioned by the HSC Board; they are largely consultant led services offering outpatient, inpatient and daycase services for a full range of eye conditions. In addition, anti-vascular endothelial growth factor injection treatment for macular diseases form part of specialist commissioning activity.

Ophthalmology services are currently provided in secondary and community care by two of the five HSC Trusts (Belfast and Western HSC Trusts). These trusts in turn offer outreach services to the remaining three trust areas.

As of 31 March 2016, the secondary care ophthalmologist workforce was as follows:

Ophthalmologists	Belfast HSC Trust		Western HSC Trust	
	Number of people	WTE	Number of people	WTE
Consultant	26	21.17	10	9.58
Associate Specialist	7	4.18		
Specialty Doctor	2	0.76		

At the time of reporting, there were three regional vacancies; two consultant grade vacancies in the Belfast HSC Trust (which are currently in the recruitment process) and one speciality doctor vacancy in the Western HSC Trust. It was noted that at the time of the review, the HSC Board was considering a business case for new and additional 2.5 WTE consultant grade appointments in the Western HSC Trust.

Consultant led clinical activity is supported by a wider team of health care professionals including optometrists, orthoptists, ophthalmic nurses and ophthalmic clinical scientists and technical support staff.

Ophthalmology is a high-volume specialty, typically accounting for around 10 per cent of all outpatient activity and 5 per cent of all surgical activity.

Demand is increasing due to the changing demographic profile, aging population, new and emerging technologies and treatments and heightened patient expectation.

This increased demand has resulted in ophthalmology being in the top four specialities across Northern Ireland with longest outpatient waits; as of September 2016 there were 21,792 people in Northern Ireland waiting for a first outpatient appointment. Of these, 16,135 were waiting in excess of the ministerial target nine weeks, and 4,543 were waiting more than one year for first appointment. In addition, many people with sight threatening conditions who require regular review and treatment are experiencing delays in booking their follow-up review appointments.

By March 2018 this number had risen; 19,424 people were waiting in excess of the ministerial target nine weeks and, 10,159 were waiting more than one year for first appointment.

Research shows that lack of routine data about delayed appointments for follow-up patients, means that hospital eye services are unable to quantify the extent of the problem or the harm coming to this, often vulnerable, patient group[37].

Current Challenges for the Service

The current HSC hospital and community eyecare services are under strain due to a range of factors. These include changing demography, rising demand, staffing vacancies, new technologies and medicines, and successful implementation of screening programmes such as the diabetic retinopathy screening programme. Service reform must occur, if high quality, safe and sustainable services are to be delivered to patients, in order to maximise vision and enhance life chances and independence[38].

Clinical leadership and partnership working are essential elements of eyecare service reform. Without the expertise of specialist staff, enhancement of skills, and provision of care closer to home, it may not be possible to meet the eyecare needs of the population of Northern Ireland. Development of regional integrated care pathways, with the involvement of primary, community, hospital and voluntary organisations, are fundamental to change. This requires optimisation of resources, both human and financial, and collaborative working across all sectors[39].

Skills, experience and equipment in primary care optometry services are available to potentially help to manage that demand and more could be done to enable citizens to self-care. Further encouragement of health promotion and identifying eye disease at an earlier stage would improve outcomes. Care pathways need to be improved across primary and secondary care, reducing variation and embedding continuous quality improvement and skills development.

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[37] http://www.nature.com/eye/journal/v31/n5/full/eye20171a.html

[38] Taken from the strategy *"Developing Eyecare Partnerships: Improving the Commissioning and Provision of Eyecare Services in Northern Ireland"*; Department of Health Oct 2012

[39] Taken from the strategy *"Developing Eyecare Partnerships: Improving the Commissioning and Provision of Eyecare Services in Northern Ireland"*; Department of Health Oct 2012

Appendix 2: DEP Project Board and DEP Task Group Membership Lists (January 2017)

PROJECT BOARD

	NAME	JOB TITLE/DEPARTMENT	ORGANISATION
1.	Dr Sloan Harper CHAIR	Director of Integrated Care	HSC Board
2.	Mr Brian McAleer	Senior Commissioning Manager	HSC Board
3.	Mr Bryan Dooley	Head of GDOS Branch and Prison Healthcare	DoH
4.	Mr Conal O'Connell	Head Accountant FHS	HSC Board
5.	Mr David Galloway	Director	RNIB
6.	Mr Dean Sullivan	Director of Commissioning	HSC Board
7.	Miss Giuliana Silvestri	Clinical Director, Ophthalmology Services	BHSCT
8.	Dr Jackie McCall **Co-Lead DEP**	Consultant in Public Health	PHA
9.	Ms Jane Hanley	Head of Orthoptic Services	BHSCT
10.	Prof. Jonathan Jackson	Head of Optometry	BHSCT
11.	Dr Karen Breslin	Chairperson	ONI
12.	Ms Katey Gunning	Innovation and Service Development Manager	HSC Board
13.	Prof. Kathryn Saunders	Professor of Optometry and Vision Science, Subject Head for Optometry	UU
14.	Mrs Louise O'Dalaigh	Ophthalmology and Optometry Service Manager	WHSCT
15.	Mr Martin Hayes	Project Director, Integrated Care Partnerships	HSC Board
16.	Mr Martin Holley	Chair, NI Ophthalmic Committee	BSO
17.	Prof. Nathan Congdon	Chair of Global Eye Health	QUB
18.	Mr Patrick Hassett	Consultant Ophthalmologist	WHSCT
19.	Mr Raymond Curran **Co-Lead DEP**	Head of Ophthalmic Services	HSC Board
20.	Mr Richard Gilmour	Head of Optometry	WHSCT
21.	Ms Sharon Gallagher	Director of Service Delivery	DoH
22.	Prof. Usha Chakravarthy	School of Medicine, Dentistry & Biomedical Sciences	QUB

TASK GROUP 1 - Workforce and Legislative Issues

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Mr Bryan Dooley CHAIR	Head of General Dental & Ophthalmic Services Branch and Prison Healthcare	DoH
2.	Mr Chris Wilkinson	Workforce Policy Directorate	DoH
3.	Mrs Emma Herron	Finance	HSC Board
4.	Ms Jenny Lindsay	Deputy Head of Optometry	BHSCT
5.	Dr Karen Breslin	Chairperson	ONI
6.	Mrs Margaret Glass	GOS Legislation (Deputy Principal)	DoH
7.	Mrs Margaret McMullan	Optometric Adviser	HSC Board
8.	Mr Patrick Richardson	Optometry Clinic Manager	UU
9.	Mr Richard Best	Ophthalmology	BHSCT
10.	Mrs Rosie Brennan	Representative	NIMDTA

TASK GROUP 2 - Integrated Models/Pathways

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Mr Raymond Curran CHAIR	Head of Ophthalmic Services	HSC Board
2.	Mr Alan Marsden	Deputy Commissioning Lead	HSC Board
3.	Mr Brian McKeown	Representative	ONI
4.	Mrs Caroline Cullen	Senior Commissioning Manager	HSC Board
5.	Mr David Galloway	Director	RNIB
6.	Mrs Emma Herron	Finance	HSC Board
7.	Miss Giuliana Silvestri	Clinical Director, Ophthalmology Services	BHSCT
8.	Dr Joanne Logan	Hospital Eye Service Optometry	BHSCT
9.	Dr Julie-Ann Little	Lecturer in Optometry	UU
10.	Mrs Margaret McMullan	Optometric Adviser	HSC Board
11.	Ms Nicola Kelly	Programme Manager, Service Development & Screening	PHA
12.	Mr Patrick McCance	Orthoptist	BIOS
13.	Mr Paul Cunningham	Commissioning Lead, Specialist Services	HSC Board
14.	Mr Stephen Boyd	Clinical Services Manager	BHSCT

TASK GROUP 3 - Regional Measurement

	NAME	JOB TITLE/DEPT.	ORGANISATION
1	Mr Martin Hayes[CHAIR]	Project Director, Integrated Care Partnerships	HSC Board
2	Ms Adrienne Hull	Eyecare Liaison Officer	RNIB
3	Mr Asif Orakzai	Consultant Ophthalmologist	WHSCT
4	Ms Caroline Earney	Senior Information Officer, PMSI	HSC Board
5	Ms Cathy Gillan	Information, PMSI	HSC Board
6	Ms Cathy Houston	Information Officer	WHCST
7	Ms Claire Stevenson	Orthoptist	SHSCT
8	Dr Jackie McCall	Consultant in Public Health	PHA
9	Ms Jane Hanley	Head of Orthoptic Services	BHSCT
10	Ms Janice McCrudden	Optometric Adviser	HSC Board
11	Mr David Galloway	Director	RNIB
12	Prof. Jonathan Jackson	Head of Optometry	BHSCT
13	Ms Katey Gunning	Innovation and Service Development Manager	HSC Board
14	Mrs Louise O'Dalaigh	Ophthalmology and Optometry Service Manager	WHSCT
15	Ms Lynn Irons	Senior Information Officer PMSID	HSC Board
16	Mr Martin Hayes	Project Director, Integrated Care Partnerships	HSC Board
17	Dr Sonia George	Ophthalmology	BHSCT
18	Miss Tanya Moutray	Consultant Ophthalmologist	BHSCT

TASK GROUP 4 - Regional Acute Eye Pathway

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Miss Giuliana Silvestri CHAIR	Clinical Director, Ophthalmology Services	BHSCT
2.	Mr Barry Curran	Representative	ONI
3.	Mr Brendan Lacey	Ophthalmology	BHSCT
4.	Mr Danny Power	Service User	N/A
5.	Dr Ciara McLaughlin	Medical Adviser	HSC Board
6.	Mrs Emma Herron	Finance	HSC Board
7.	Ms Fiona North	Optometric Adviser	HSC Board
8.	Ms Jane Hanley	Head of Orthoptic Services	BHSCT
9.	Dr Karen Breslin	Representative	ONI
10.	Mrs Louise O'Dalaigh	Ophthalmology and Optometry Service Manager	WHSCT
11.	Mrs Margaret McMullan	Optometric Adviser	HSC Board
12.	Mr Matthew Dolan	Pharmacy Co-ordinator (Belfast)	HSC Board
13.	Mr Raymond Curran	Head of Ophthalmic Services	HSC Board
14.	Mr Richard Gilmour	Head of Optometry	WHSCT
15.	Sr Rosemary O'Neill	Sister, Eye Casualty	BHSCT
16.	Mr Stephen Boyd	Clinical Services Manager	BHSCT
17.	Miss Suhair Twaij	Clinical Lead for Eye Casualty	BHSCT

TASK GROUP 5 - Promotion of Eye Health

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Dr Jackie McCall CHAIR	Consultant in Public Health	PHA
2.	Dr Chris Leggett	GP Lead	Down ICP
3.	Mr David Barnes	Service Delivery Manager	Guide Dogs NI
4.	Mr David Galloway	Director	RNIB
5.	Dr Deirdre Burns	Optometrist	BHSCT
6.	Prof. Kathryn Saunders	Education and Research	UU
7.	Dr Mark Holloway	GP with Special Interest	RCGP
8.	Ms Patricia Dolan	Orthoptist	NI Orthoptic Managers' Forum
9.	Mr Patrick Hassett	Consultant Ophthalmologist	WHSCT
10.	Ms Rachel Scott	Executive Council Member	ONI
11.	Mr Stephen Wilson	Communications & Knowledge Management	PHA
12.	Ms Shauna McCrea	Project Manager, Physical & Sensory Disability Strategy	HSC Board
13.	Dr Damien Bennett	SpR Public Health Medicine,	PHA

CVI Subgroup – Reporting to Task Group 5

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Mr David Galloway CHAIR	Director	RNIB
2.	Mr Aidan Best	Team Leader Sensory Support Services	BHSCT
3.	Mr Bryan Dooley	Head of General Dental & Ophthalmic Services Branch and Prison Healthcare	DoH
4.	Ms Jenny Lindsay	Deputy Head of Optometry	BHSCT
5.	Prof. Jonathan Jackson	Head of Optometry	BHSCT
6.	Ms Martina Dempster	Senior Social Worker Sensory Services	WHSCT
7.	Miss Tanya Moutray	Consultant Ophthalmologist	BHSCT

10,000 Voices Working Group

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Dr Jackie McCall CHAIR	Consultant in Public Health	PHA
2.	Ms Adrienne Hull	Eyecare Liaison Officer	RNIB
3.	Ms Christine Armstrong	Regional Lead, 10,000 Voices Project	SESCT
4.	Mr Colin Jackson	Facilitator, 10,000 Voices Project	BHSCT
5.	Ms Eileen McCay	Clinical Co-ordinator	WHCST
6.	Ms Glynis Jones	Specialist Nurse, Glaucoma	BHSCT
7.	Ms Helen McAtamney	Imaging Technician	BHSCT
8.	Ms Janice McCrudden	Optometric Adviser	HSC Board
9.	Mrs Louise O'Dalaigh	Ophthalmology and Optometry Service Manager	WHSCT
10.	Mr Martin McComb	Charge Nurse, Macular	BHSCT
11.	Mr Shaun Canny	Campaigning Active Network Officer	RNIB
12.	Dr Jacqueline Witherow	Campaigns and Research Manager	RNIB
13.	Dr David Armstrong	Specialist Register Ophthalmology	BHSCT

DEP Research Group

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Prof Nathan Congdon CHAIR	Chair of Global Eye Health	QUB
2.	Mr David Galloway	Director	RNIB
3.	Dr David Wright	Research Fellow, School of Medicine, Dentistry and Biomedical Sciences	QUB
4.	Dr Jackie McCall	Consultant in Public Health	PHA
5.	Prof Jonathan Jackson	Head of Optometry	BHSCT
6.	Dr Julie-Ann Little	Lecturer in Optometry	Ulster University
7.	Prof Kathryn Saunders	Professor of Optometry and Vision Science, Subject Head for Optometry	Ulster University
8.	Mr Raymond Curran	Head of Ophthalmic Services	HSC Board
9.	Mr Robbie Morrison	Postgraduate research student, School of Medicine, Dentistry and Biomedical Sciences	QUB
10.	Dr Ruth Hogg	Lecturer, School of Medicine, Dentistry and Biomedical Sciences	QUB

Appendix 3: DEP Project Task Group and Subgroup Terms of Reference[40]

Task Group 1 – Workforce and Legislative Issues

DEP Objectives	Terms of Reference	Measurable Outcomes
Objective 3 – In order to promote service quality, the Department of Health will consider introducing primary legislation which, subject to Assembly approval, will enable the HSC Board to develop and maintain an extended listing system of individual practitioners involved in the provision of GOS. Objective 4 - A Northern Ireland Sight test Survey will be re-commissioned in order to fully understand the level and type of demand for sight tests in GOS, to include referral patterns, demographics, co-morbidities and the level of private practice undertaken. Objective 10 – Clinical leadership, workforce development, training, supervision and accreditation will be essential components of eyecare service reform. This includes the promotion of independent optometrists' prescribing, where appropriate to do so. Objective 12 - The HSC	1. To set the context for the introduction of proposals for an extension and enhancement of the current arrangements for listing of ophthalmic practitioners. 2. To detail the proposed changes to the arrangements for list admission to ensure that the list provides governance and protection for patients from any practitioner who is not suitable or whose performance may be impaired. 3. To define the enablers for change as defined within DEP including the necessary legislative changes. 4. To set the context for the re-introduction and development of the framework for the Northern Ireland Sight Test Survey detailing the need for the survey in an enhanced format to include indicators for preventable sight loss. 5. Liaise with academic, training institutions, other bodies and DEP Task Groups to develop a suite of	Introduction of revised listing arrangements supported by regulatory and/or legislative change. Establishment of DEP Task Groups to identify and action the enablers for change Re-introduction of an added value Northern Ireland Sight Test Survey with information provided from it to be used to inform service provision and support the work of other DEP Task Groups. The establishment of a framework for all aspects of ophthalmic training – undergraduate, post graduate and specialist training. The assessment of the quality of provision of training, outcomes of the training and uptake of said training.

[40] http://www.hscboard.hscni.net/download/PUBLICATIONS/OPTOMETRY/developing_eyecare_partnerships/DEP-Annual-Report-2016.pdf

Board/PHA working in collaboration with relevant organisations will lead on the implementation of the eyecare strategy. The Department of Health will lead on any legislative change.	training programmes for pre-registration and specialist list ophthalmic professionals in order that enhanced services received appropriate training and accreditation	

Task Group 2 – Integrated Models/Pathways

DEP Objectives	Terms of Reference	Measurable Outcomes
Objective 5- An integrated eyecare service model will be implemented which will facilitate a resource shift, with improved inputs, access and outcomes at each level- primary and community, networked acute care and highly specialist regional and supraregional services. Objective 6a- There will be a regional approach to the development of integrated care pathways for long-term conditions to include glaucoma, cataract, diabetic retinopathy, macular degeneration and low vision; these pathways will adopt the ten principles of service change in order to enhance access, and improve eye health outcomes. Objective 8- Eyecare Partnership Schemes, to enhance access to diagnosis and treatment closer to home, will be based on populations needs. These will be developed regionally and commissioned by the HSC Board working in collaboration with Local Commissioning Groups. These funded schemes will	1. To ensure that eyecare service models are in line with DEP and TYC objectives. 2. To ensure that eyecare service models for long term conditions are in line with DEP, TYC and the wider Vision 2020 agenda. 3. To develop a network of communication to enable the development of eyecare partnerships which will facilitate development of patient-centred care pathways in line with population needs and TYC direction. 4. To develop a framework to ensure that ICT is an enabler within care pathways and payment and probity systems.	To identify clinical pathways for optimum service provision for 1. Acute Eye 2. Specialist Services 3. Glaucoma 4. Cataract 5. Diabetic Retinopathy 6. Macular Degeneration 7. Low Vision To establish local and regional professional groups from all stakeholders including: ICPs, LCGs, Trust, voluntary sector and service users. The establishment of care pathways and their associated business plans. The delivery of full connectivity across primary and secondary care ensuring maximum efficiencies, improved pathways and patient safety.

be part of new pathway approaches for the delivery of services for common eye conditions. Objective 11- ICT developments will be required to improve referrals, communication, payment and probity systems. Telemedicine links have the capacity to improve the quality and efficiency of service provision.		

Task Group 3 – Regional Measurement

DEP Objective	Terms of Reference	Measurable Outcomes
Objective 7- There will be high level regional measurements to facilitate the monitoring and evaluation of the new eyecare service model and associated pathways. This will include input, output and outcomes measurements.	1. To identify current service measurements to establish a service baseline 2. To benchmark existing service provision across all Trusts 3. To identify other measurements and audit tools to evaluate the impact of the pathway redesigns emanating from DEP Task Groups	To provide audit data on the outputs of DEP in relation to access, clinical outcomes and patient experience with recommendations for ongoing service improvement.

Task Group 4 – Regional Acute Eye Pathway

DEP Objective	Terms of Reference	Measurable Outcomes
Objective 9 –A regional pathway will be developed for the diagnosis and management of the “acute eye*” across the primary, community and hospital interfaces. This pathway will need to consider how best to maximise resources-both human and financial-and be commissioned and delivered within an appropriate governance framework. **acute non-sight threatening eye*	1. Review current NI and national pathways for diagnosis and management of “acute eye” including primary care optometry, GP and pharmacy involvement and secondary care - HES/RAES. 2. To recommend a redesigned care pathway for the management of acute, non-sight threatening eye conditions across primary and secondary care.	1. A business plan and redesigned care pathway encompassing elements of patient self-care, primary care treatment and advice and seamless transition in to secondary care where appropriate. 2. A public health awareness and communication strategy in relation to “acute eye problems” (to include eye injuries). Linkage with DEP Task Group 5 to ensure alignment with overarching HSC strategies (e.g. Choose Well) 3. Reduction in the number of attendees at Eye Casualty in the RVH by providing services nearer to home. 4. Multidisciplinary teams to manage the acute eye in peripheral locations.

Task Group 5 – Promotion of Eye Health

DEP Objectives	Terms of Reference	Measurable Outcomes
Objective 1-HSC Organisations will collaborate with other organisations to deliver on the aims set out in ‘*Fit and Well-Changing Lives (2012-2022)*’ and other related strategies, in order to contribute to the promotion of good eye health and prevent eye disease. Objective 2-Through implementation of the Service Framework for Older People (post	1. To identify prevention strategies to reduce sight loss and visual impairment in line with ‘Fit and Well – changing lives’ and other relevant strategies. 2. To identify and prioritise opportunities for primary prevention, secondary prevention and early detection to promote eye health to the population of Northern	To review all current strategies and extract references to eye health promotion To review evidence – undertake a literature review of prevention of sight loss eye health in UK and identify need for any further work or work specific to Northern Ireland. To review what is actually being delivered in Northern Ireland with respect to sight loss prevention and promotion of eye health

consultation and subject to the final determination of the relevant standard), HSC organisations will offer multi-factorial, evidence based falls and bone health assessments to older people on an annual basis. This will adopt a case management approach for those at high risk of falls, including eyesight tests and the enhancement of signposting on access to ophthalmic services in primary and community care.	Ireland using a life course approach. 3. To engage and work collaboratively with HSC bodies, voluntary sector and service users to establish and implement an action plan for the promotion of eye health and prevention of sight loss.	To create an action plan for the promotion of good eye health and sight loss prevention in Northern Ireland in light of information obtained within this workstream.

CVI Subgroup of Task Group 5

DEP Objective	Terms of Reference	Measurable Outcomes
6b. Pathways for eyecare will ensure that blind/partially sighted certification and registration processes are appropriately conducted.	1. Examine the application of the CVI and Registration processes in Northern Ireland and submit specific recommendations for change or improvement to DEP Project Board. 2. Engage with Task Group 2 to ensure CVI processes are reflected in care pathways 3. Engage with Task Group 1 to ensure that an effective regulatory framework is in place for certification.	Arrangements for certification of visual impairment operate in the best interests of patients and are consistently applied across Northern Ireland

10,000 Voices Working Group

DEP Objective	Terms of Reference	Measurable Outcomes
Objective 7- There will be high level regional measurements to facilitate the monitoring and evaluation of the new eyecare service model and associated pathways. This will include input, output and outcomes measurements.	To undertake a SenseMaker Audit for eyecare services involving users, carers and staff from Belfast and Western Trusts to obtain feedback on their experience of eyecare services. Findings and recommendations from the outcome of the Audit will inform service change, improvements and future development.	Audit Report, including findings and recommendations.

DEP Research Group

DEP Objective	Terms of Reference	Measurable Outcomes
Objective 12a - HSC Board /PHA working in collaboration with relevant organisations will lead on the implementation of the eyecare strategy.	To establish a research agenda for DEP in order to implement feasible and important interventions to improve eye health for people of Northern Ireland.	Research agenda established.

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