DEVELOPING EYECARE PARTNERSHIPS 2012-2017

Improving the Commissioning and Provision of Eyecare Services in Northern Ireland

FINAL PROJECT REPORT
October 2017

Department of Health | An Roinn Sláinte / Männystrie O Poustie

HSC Health and Social Care Board

HSC Public Health Agency

Contents

1. Introduction

This report provides an overview of the key pieces of work carried out through the Developing Eyecare Partnerships (DEP) Project between October 2016 and September 2017.

The report also highlights some of the work carried out by each DEP group in the project's first four years from October 2012 to September 2016.

This report can be made available in other formats. Please contact the Health and Social Care Board on 0300 555 0115 and ask for a member of the Ophthalmic Services team.

1. Aims and Context

The five-year strategy **Developing Eyecare Partnerships: Improving the Commissioning and Provision of Eyecare Services in Northern Ireland**[i] was launched by the then Department of Health, Social Services and Public Safety in October 2012. The Developing Eyecare Partnerships (DEP) Project was subsequently established to implement the strategy and grew into a multi-agency, multi-disciplinary partnership involving over 90 senior leaders from across the health and social care and voluntary sectors.

The overarching aim of this regional strategy was to minimise sight loss and reduce health inequalities.

As our populations age, and the age group most at risk of visual disorders increases, demand for eye services continues to grow. New and emerging technologies and treatments mean that more eye diseases are treatable, but often require long-term monitoring. Pivotal to good eye health is the embracing of the wider public health messages in order to promote good visual health, prevent eye disease and have appropriate and timely clinical interventions to maximise sight.

Aims of the DEP Strategy

- Identify potential sight-threatening problems at a much earlier stage.
- Contribute to the independence of adults and maintaining them well in the community, for as long as possible, by improving access to current Health and Social Care (HSC) treatment for acute and/or long-term eye conditions.
- 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.
- Maximise use of HSC resources in both primary and secondary care services.

DEP focussed on reform, modernisation and transformation of how and where we deliver eyecare, aligned to the Department's Five Year Elective Care Plan and **Health and Wellbeing 2026: Delivering Together**[ii]

The DEP Strategy followed the model for change set out in **Transforming Your Care – A review of Health and Social Care in Northern Ireland**[iii] (2011), which focused on reshaping how services are to be structured and delivered in order to make best use of all resources and, in so doing, ensure that services are safe, resilient and sustainable into the future.

The identification of the need for change is not restricted to Northern Ireland. For example:

The **UK Vision Strategy 2013-2018**[iv] similarly sets out the case for change. Outcome 2 of the UK Vision Strategy asserts that "everyone with an eye condition receives timely treatment and, if permanent sight loss occurs, early and appropriate services and support are available and accessible to all."

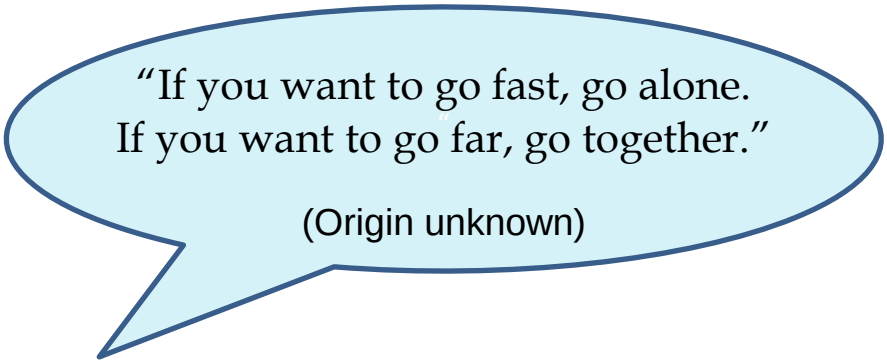
The VISION 2020 UK Ophthalmic Public Health Committee has produced a **portfolio of eye health indicators**[v] to support review and monitoring of eye health of the population at a national level.

The work of the DEP Project also aligned well with **The Royal College of Ophthalmologists' "Three Step Plan"**[vi], launched in 2016. The plan focuses on three areas to address the challenges facing overwhelmed hospital eye services:

1 Collect and Report Data;
2 Maximise capacity – use all resources effectively; and
3 Empower and Inform Patients – promote personal responsibility.

The Clinical Council for Eye Health Commissioning (CCEHC) is a partnership of the leading eye health organisations in England acting as the national clinical voice for eye health, advising commissioners, providers, clinicians and policy-makers in health, social care and public health on all matters related to improving the eye health of their populations. In June 2016, the CCEHC published the **Primary Eye Care Framework**[vii] to support the delivery of appropriate eyecare services in the primary (eyecare) setting, where it is safe to do so. This framework maps well to the DEP Strategy which has already enabled progress in Northern Ireland with respect to glaucoma referral refinement, acute eye management and patient and user involvement, with potential plans for more primary care involvement in the cataract pathway.

2. Approach and Structure



The DEP Project provided a coordinated approach for the commissioning and delivery of eye health and sight loss services to support the integration between services and pathways.

The DEP Project facilitated the development of appropriate care pathways, across all sub-specialties where appropriate, from primary care through to specialised secondary care utilising the expertise of a varied skill mix. Supporting these pathways is the use of optimal technologies and seamless communication between those providing the care.

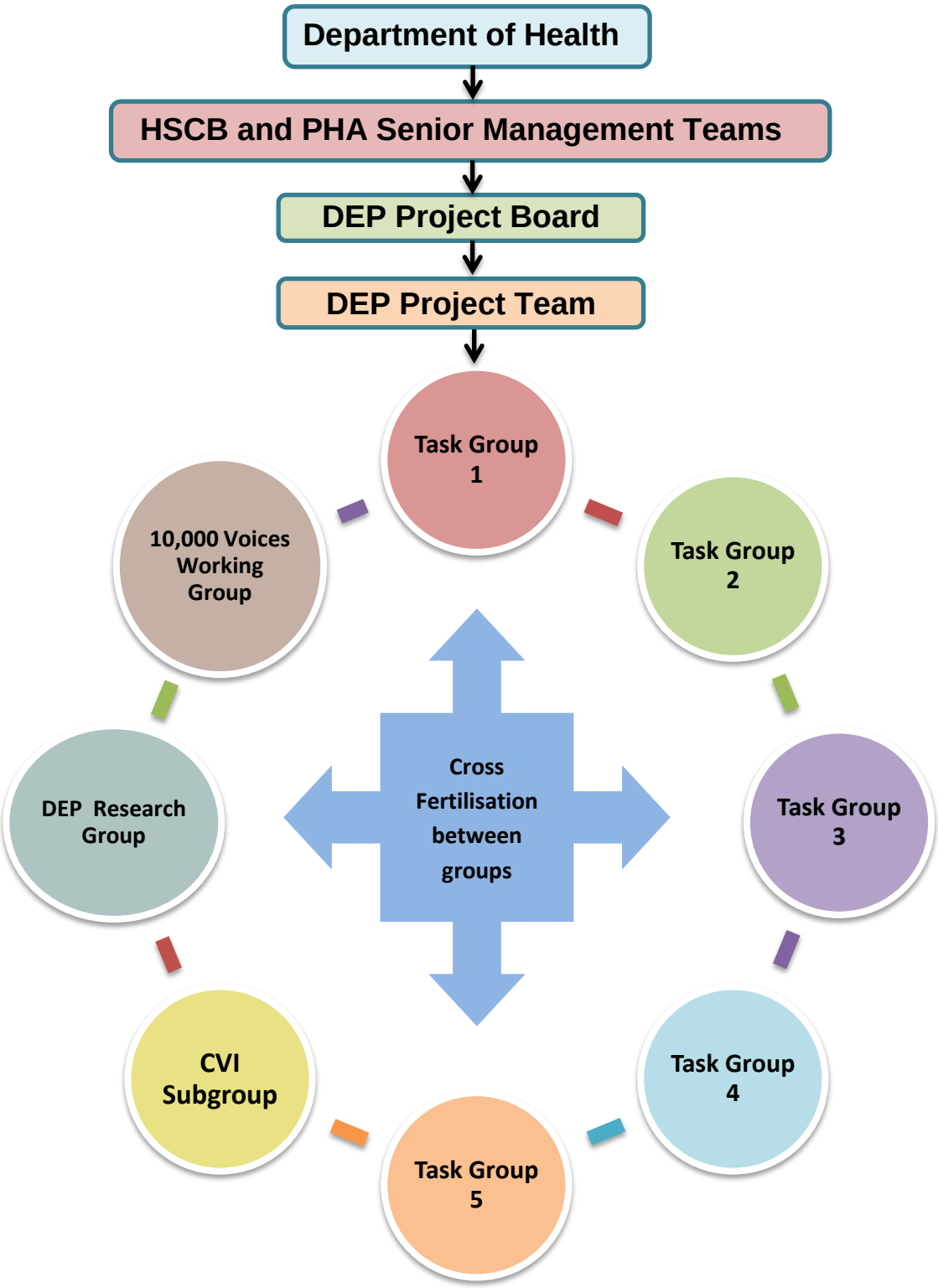
The DEP Project was sponsored and overseen by the Department of Health (DoH). The Health and Social Care Board (HSCB) and Public Health Agency (PHA) co-led on the implementation of the strategy over the five year period from 2012 to 2017.

DEP Membership was drawn from those with experience in the clinical delivery of eyecare, the management of eyecare service provision, the field of academia and professional training and from the voluntary sector with particular emphasis on vision and service provision for visually impaired persons.

Appendix 1 details the membership of the DEP Project Board.

Appendix 2 details the membership of the various project groups and their DEP Objectives. The structure of the DEP Project was such that it enabled cross-fertilisation of ideas, innovation and work.

DEP Project Structure



3. Task Group 1 - Workforce and Legislative Issues

Task Group 1 was led by the Department of Health (DoH) and had three objectives relating to legislation, workforce planning and the Northern Ireland Sight Test and Ophthalmic Health Survey.

DEP 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 General Ophthalmic Services."

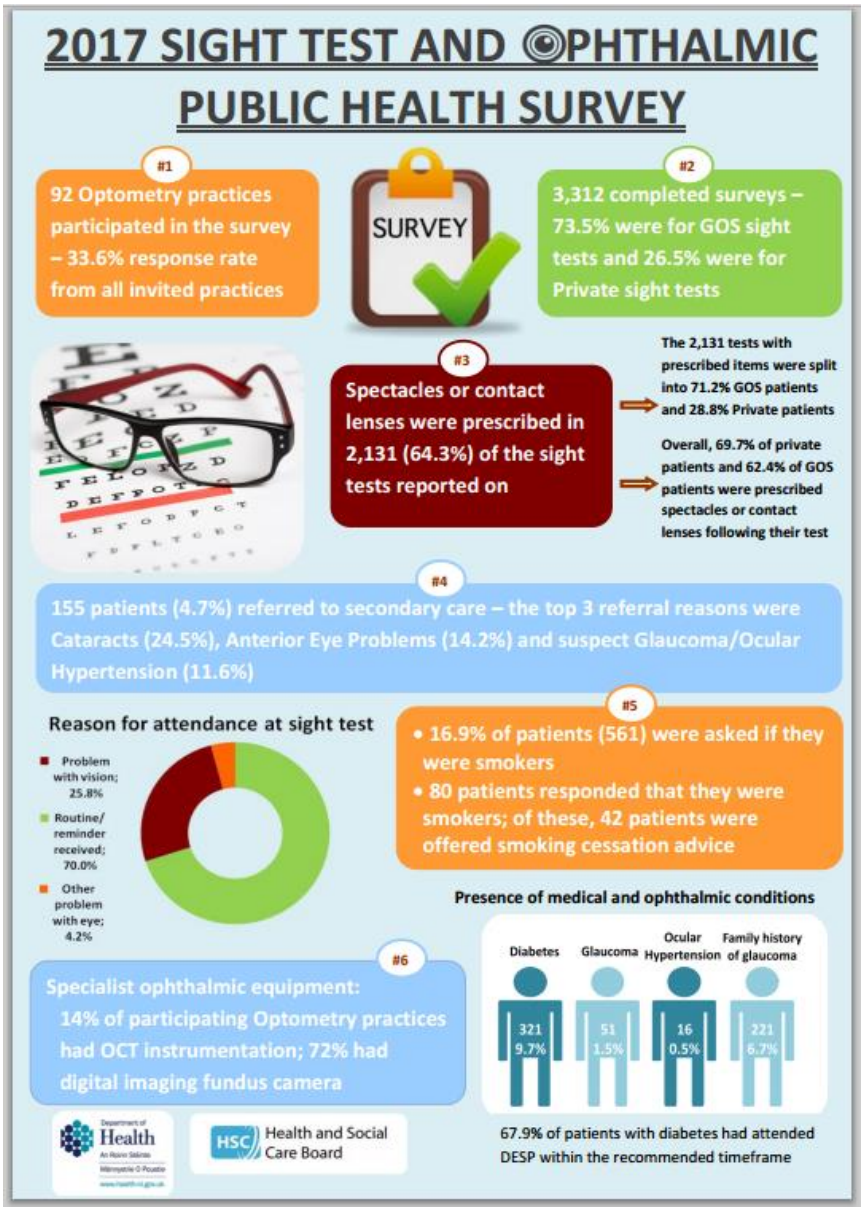
Ophthalmic Listing arrangements vary across the United Kingdom. In Northern Ireland, only contractors who have made arrangements with the Health and Social Care Board to provide General Ophthalmic Services (GOS) are required to be listed. Limited information is required about individual practitioners who assist contractors in the provision of GOS. The current Regulations which govern GOS provision are made under the powers in the primary legislation i.e. within the Health and Personal Social Services (NI) Order 1972, and hence any changes required to deliver on Objective 3 and extend listing to individual practitioners require primary legislative change.

The Department of Health and the Health and Social Care Board worked together to agree amendments to the current GOS Regulations with the aim of improving governance and quality assurance processes and the administrative management of GOS. Draft amending Regulations were sent to Departmental legal advisers and full consultation on the amended Regulations is scheduled to take place upon the resumption of Assembly business.

Work to address Objective 3 requires enabling amendments to primary legislation. This cannot take place until the reform of health and social care in Northern Ireland has been completed and new structures and arrangements are in place, when it will be known where responsibility and accountability for GOS provision sits.

DEP 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."

As an outcome of the 2014 Sight Test and Ophthalmic Public Health Survey (see below, "Highlights from 2012-2016"), the Department of Health supported and committed to the delivery of the Survey again in 2017. From the outset, it was important to recognise the need to learn from and to build on the success of the 2014 Survey. A review of the previous methodology, modality of survey, data capture and data analysis was undertaken. Key findings from the 2017 survey are presented below. The full survey may be accessed here: https://www.health-ni.gov.uk/sites/default/files/publications/health/ni-sts-17.pdf



This infographic may be viewed more clearly from https://www.health-ni.gov.uk/sites/default/files/publications/health/ni-sts-flyer.pdf

DEP 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."

Throughout Year 5, Task Group 1 continued to support the other Task Groups in the development of a **DEP Training and Professional Development Plan** to identify the elements of workforce development necessary to deliver on the reform and integration agenda of DEP. This plan is included as **Appendix 4**.

Delivery on the elements identified within this plan has been ongoing since the beginning of DEP. This has included the promotion of independent optometrists' prescribing, where appropriate to do so. The Belfast and Western Health and Social Care Trusts developed a framework of clinical placements for IP Optometrists-in-training to facilitate equitable and on-going access to mandatory clinical experience for optometrists. The Trusts have been supported in their provision of these placements through funding from the Department of Health.

Task Group 1 also began to examine the role of Quality Improvement (QI) and how it can influence change and reform of eyecare service provision. Challenges will always exist in this area as investment in clinical leadership, workforce development, training, supervision and accreditation requires resources. Commissioners, clinicians, managers and decision-makers are required to be especially innovative in their approach during challenging economic times.

In Year 5, work began to propose the development of a Workforce Development Plan for eyecare services. In order to meet the needs of the population now and in the future, it will be important to understand which ophthalmic subspecialties will be more in demand, and how expanded use of multi-disciplinary teams (MDT's) will impact on the system.

Task Group 1 Highlights 2012-2016

Task Group 1 examined the frameworks which exist in England, Scotland and Wales in order to determine the best **regulatory framework** for GOS Northern Ireland. It is agreed that any proposed model for provision of General Ophthalmic Services should take account of the strategic direction of the DEP Project, optimising the optometric workforce and ensuring that regulatory powers are robust and fit for purpose. In 2015/16, DEP Task Group 1 liaised with the Department of

Health to provide appropriate advice to the legislative work to amend the Health (Miscellaneous Provisions) Act (NI) 2008 via the **Miscellaneous Provisions Bill**[viii] which is now enacted.

Task Group 1 also developed and delivered an added-value **Northern Ireland Sight Test and Ophthalmic Public Health Survey**[ix] in June 2014. The 2014 Survey was an enhancement on the previous (2007) Sight Test Survey and included data capture on elements of ophthalmic public health, which have provided baseline information which informed service planning and provision. The 2014 Survey report provided information and evidence on many elements of eyecare provision and primary care ophthalmic 'activity' in terms of numbers and demographics of people accessing optometry services in Northern Ireland.

4. Task Group 2 - Integrated Models/Pathways

DEP OBJECTIVE 5 "An integrated eyecare model will be implemented which will facilitate a resource shift, with improved inputs, access and outcomes at each level i.e. primary and community, networked acute care and highly specialist regional and supra-regional services."

DEP OBJECTIVE 6a "There will be a regional approach to the development of integrated care pathways for long term eye conditions to include glaucoma, cataract, diabetic retinopathy, macular degeneration and low vision; these pathways will adopt the ten principles of eyecare service change in order to enhance access, and improve eye health outcomes."

DEP OBJECTIVE 8 "Eyecare partnership schemes, to enhance access to diagnosis and treatment closer to home, will be based on population needs. These will be developed regionally and commissioned by the HSC Board working in collaboration with Local Commissioning Groups. These funded schemes will be part of new pathway approaches for the delivery of services for common eye conditions."

As with other UK regions, demand is in danger of outstripping capacity in the major subspecialty areas of glaucoma, cataract, macular disease and diabetic retinopathy. As such, a major focus on DEP was to plot pathways, taking into account NICE and other relevant guidelines, reducing variation, and maximising resource to streamline services and improve clinical and patient-reported outcomes.

Reform and transformation is around co-producing and developing service specifications to manage more (where safe and appropriate) in primary care, integrate better across primary and secondary care, and modernise secondary care services by improving flows, co-locating diagnostics and treatments, and use of a consultant-led, multi-disciplinary team model.

The consultation prior to publication of the DEP Strategy in 2012 stated that the "overall aim in developing this framework is to increase the services that are currently provided by primary care providers, in

partnership with secondary care clinicians, thereby helping to reduce the current pressure on secondary care services."

Delivery on Objectives 5, 6a and 8 tested a number of theories:

- Non-medical practitioners, including optometrists, nurse practitioners and orthoptists, working independently, caring for patients by following predefined protocols in defined areas of ophthalmic care, can maintain or improve the quality of care and outcomes for patients.
- Developing genuine partnerships between community and hospital providers and the patient and carer, both in service planning and delivery, can improve access and choice, and deliver patients' aspirations for responsive and convenient services.
- With further training and accreditation, together with the adoption of protocol-based care, optometrists and others can provide a standardised high quality service that benefits the overall eyecare pathway.
- Enhanced services can be as cost-effective, or more, than traditional care pathways.
- Enhanced services are accepted as an effective alternative to traditional models of care by patients, providers and all stakeholders.
- Those patients who do require care to be delivered in a secondary care setting can expect to have regionally-consistent access, co-located diagnostics and treatment, clinical outcomes, and access to support services where required.

The DEP Project's work on the Glaucoma/OHT pathway indicates that full utilisation of the primary and secondary care workforce might better manage demand for this lifelong condition. By coordinating governance arrangements, ensuring quality standards are in place and with enhanced IT and communications systems, risk-stratified care for patients with low risk glaucoma and macular conditions might be monitored in the community setting.

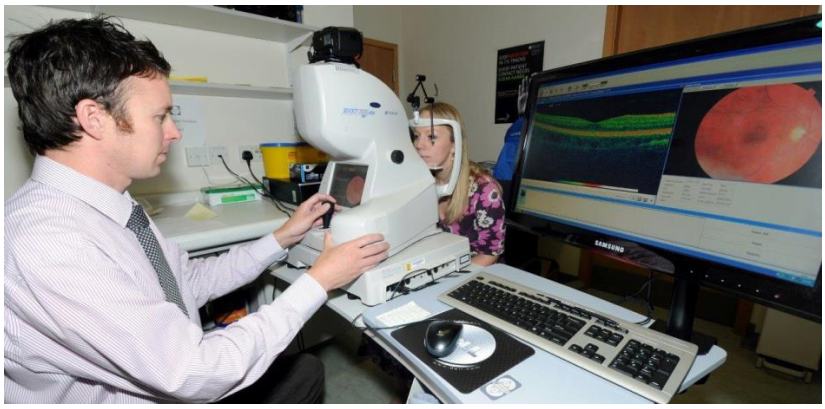
Helen Ritchie, Glaucoma Nurse Specialist, carrying out slit lamp examination at the glaucoma service

In Year 5, the DEP Project further developed these strategies, and continued to progress community-based post-operative cataract care. Quality assurance and audit are central to these strategies.

The integration of GOS referrals into the Clinical Communications Gateway (CCG) and planned access for GOS practitioners to the Northern Ireland Electronic Care Record (NIECR) further enhances system-wide integration and widens the possibilities for co-ordinated primary care facing service provision, where safe and appropriate.

The original premise for glaucoma service community optometrists with a special interest (COSIs) was that these skills would be exported, with IT links and strong clinical leadership, into locality-based Ophthalmic Clinical Centres, for ophthalmic services. The BHSCT plans to develop these one-stop centres brings this vision a step further and also opens the possibility for "teach and treat" clinical rotations for experienced GOS practitioners within these centres.

In 2017, the DEP Project developed these pathway and workforce planning streams to ensure that pathways are maximised to improve access, patient experience and outcomes and make best use of all available resources.



Optometrist Ivan Drinan of WHSCT uses Ocular Coherence Tomography (OCT) in assessing macular disease

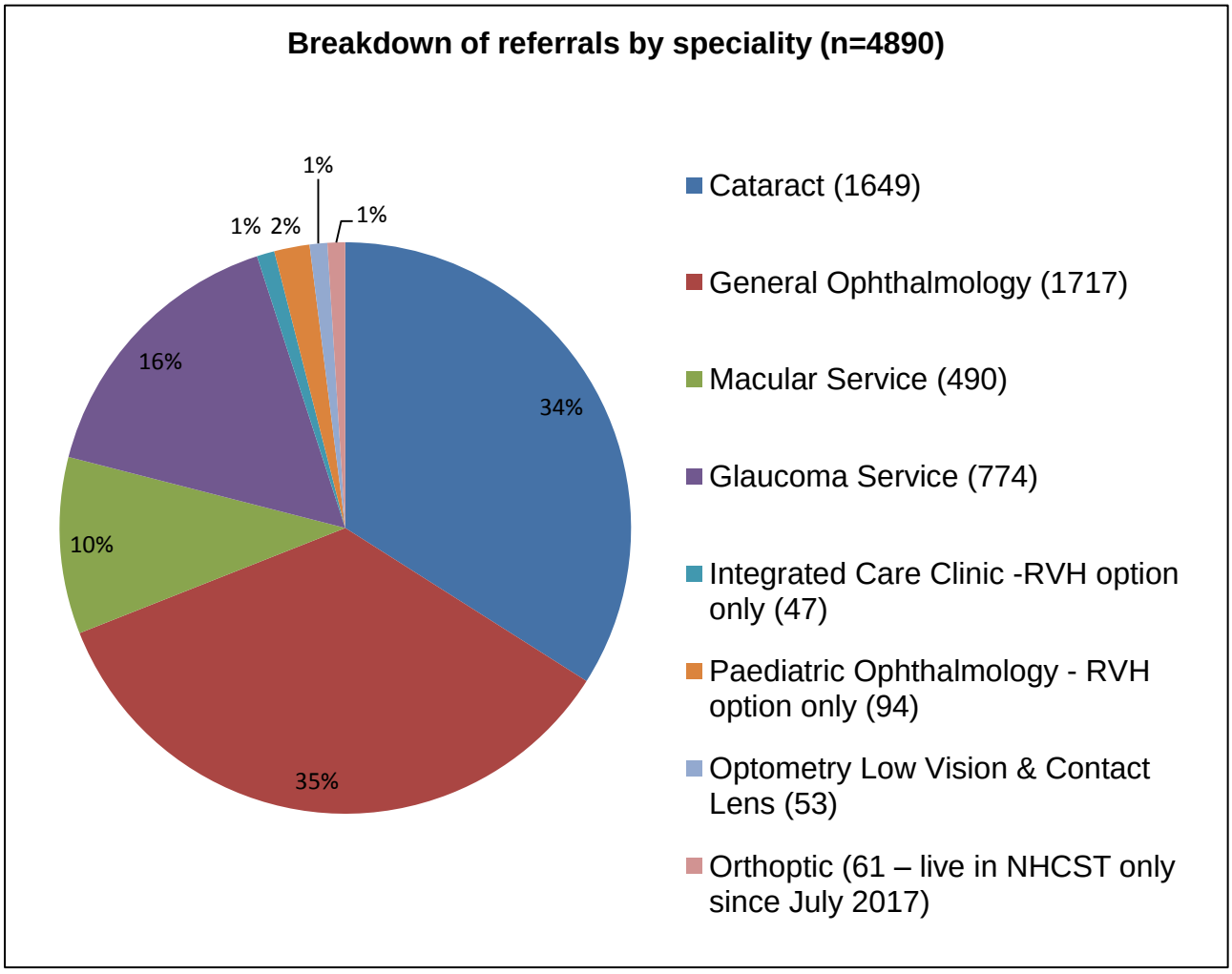
DEP OBJECTIVE 11 "ICT developments will be required to improve referrals, communications and, payment and probity systems. Telemedicine links have the capacity to improve the quality and efficiency of service provision."

Ophthalmology is a high demand specialty, accounting for approximately 10% of all referrals regionally. As most of these are generated within General Ophthalmic Services, and currently generally routed via a patient's GP, streamlining this process carries significant direct patient benefit in terms of reduction of duplication and waste, and improved patient safety.

Referral Activity by Sub-specialty Pathway

The following chart demonstrates an analysis of eReferral activity in optometry practices from November 2016 to September 2017. Analysis of referral activity allows better planning and informs the workforce planning agenda

The total referrals via the Clinical Communications Gateway (CCG) during this time period was 4,890, from 147 practices out of a total of 193 which were enabled to use CCG by 6/9/17.



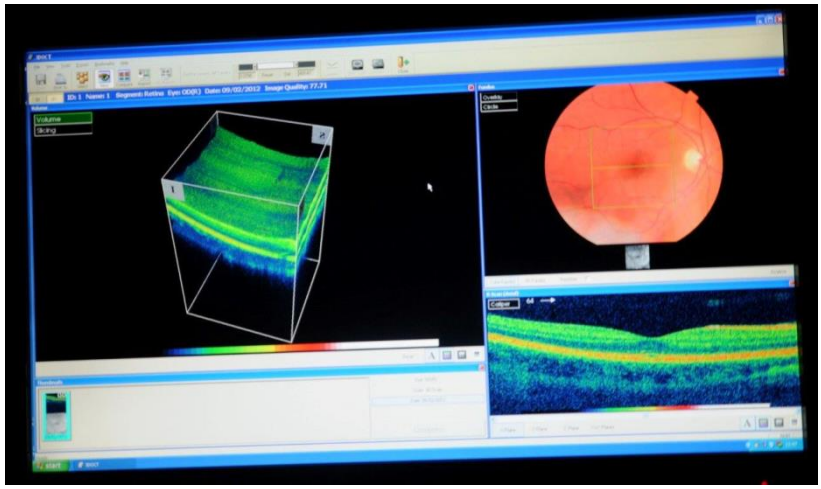
The DEP Project has fed into the HSCB/PHA wider eHealth strategy, and has taken the opportunity to input into eHealth Commissioning Intentions for 17/18 and beyond. One facet of this intention is to deliver on the commitment contained within **Health and Wellbeing 2026: Delivering Together**[ii] to pilot GOS access to NIECR. This access, leading to full integration within the NIECR successor "Encompass" programme, would have direct system and patient benefits, and may be best achieved by full primary care access to a managed HSC IT infrastructure network, subject to business case approval.

Task Group 2 Highlights 2012-2016

The **Glaucoma/Ocular Hypertension (OHT)** pathway continued to benefit from primary care demand management by "repeat measures" refinement. The repeat measures local enhanced service continues to reduce referrals into secondary care by 65%. Advanced case finding builds on this where it is safe and appropriate to do so. Waiting times in the Glaucoma Service in Belfast Health and Social Care Trust were reduced as a result of direct investment, and service re-design and partnership working has facilitated direct benefit for patient care.

In the **Macular Service** (including wet age-related macular degeneration, retinal vein occlusion and diabetic macular oedema), a new rapid-access referral protocol has been agreed and implemented regionally, ensuring that signs and symptoms are accurately recorded and that patients are involved in decisions around their care and are directed in a timely manner to the most appropriate clinical setting. In the treatment setting, new models of care again ensure that the skills of the workforce are maximised, and adoption of new technologies (including virtual imaging) are optimised.

A screenshot of Ocular Coherence Tomography (OCT) which supports ophthalmologists and optometrists in assessing macular disease



Initiatives on re-configuring the flows and streams of macular service provision, in addition to the development of the extended role of Advanced Nurse Practitioners, resulted in Belfast Health and Social Care Trust's Macular Service winning joint First Place in the Resources category of the 2016 BHSCT Chairman's awards.

In tandem with recommendations from RQIA, following the 2015 Review of the Diabetic Eye Screening Programme, the PHA-commissioned programme continues to undergo significant modernisation to both meet the RQIA recommendations and plan for the future in line with 4-Nation National Screening Committee advice. This modernisation helps to ensure that uptake of screening for all eligible people is maximised and those suspected of having **diabetic retinopathy** have timely access to treatment.

Building on early DEP initiatives to manage demand for cataract surgery, work has commenced to both gauge patient experience and outcome indicators around cataract surgery and to scope the potential to "step down" selected post-operative cataract review patients to primary care optometry, thereby freeing capacity in secondary care.

2016 witnessed the piloting and successful outcomes of a world-first ophthalmic **Project ECHO**©. This transformational and innovative tele-mentoring initiative, moving knowledge not people, demonstrated that primary care optometrists have the skills and knowledge to help manage demand for ophthalmic long term conditions, including glaucoma/OHT and macular services. The **Evaluation of Project ECHO (Extension for Community Healthcare Outcomes) Northern Ireland Programme 2015-6**[x] report was produced by Northern Ireland Hospice in May 2016. This report indicated that ECHO facilitated a statistically significant improvement in both self-efficacy and demonstrable skillsets around recognising and monitoring risk-stratified glaucoma and macular patients. It is hoped that this governance and learning tool will form part of future models of care within these pathways.

Due to work carried out between 2012 and 2016, GOS contractors now benefit from an **electronic claims platform** (OCS) allowing a fast and reliable payments system, improved cash flow analysis, increased data security and a patient-centred HSC look-up capability.

As GOS contractors are not currently part of the HSC managed network, access to the OCS portal is by way of secure crypto-card encryption. This same portal access opens the doors to other technologies to help improve referrals, communications and patient management systems.

In 2016, the DEP Project oversaw the planning and development of systems to permit secure electronic referrals from primary care optometrists to secondary care colleagues. Working with multiple stakeholders, including the Business Services Organisation (BSO) Information Technology Service, secondary care clinicians and managers, and primary care referrers, this eReferral via the Clinical

Communications Gateway (CCG) has revolutionised both the referral and the feedback process, helping to manage demand and improving patient safety.

Primary care Optometrist Mr Richard Mackey carrying out the first e-referral in 2016 for patient Mrs Newell

5. Task Group 3 - Regional Measurement

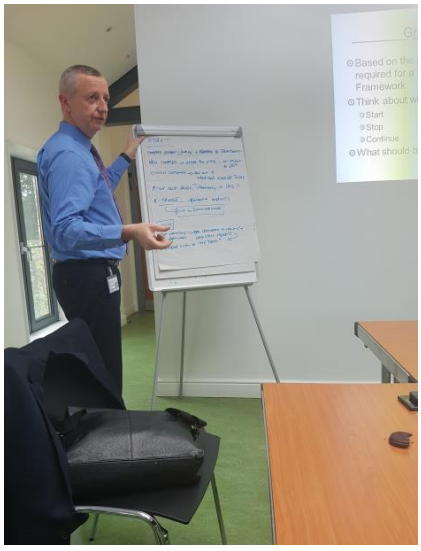
DEP OBJECTIVE 7 "There will be high level regional measurements to facilitate the monitoring and evaluation of the new eyecare service model and associated pathways. This will include input, output and outcomes measurements."

In order to effectively monitor and evaluate the improvements in eyecare pathways which have been realised by the work of the DEP Project, it is important to consider what measurements, both quantitative and qualitative, are required. The task of determining what elements of "activity" and "clinical care" accurately reflect the quality of eyecare provision is challenging and, as service improvements and quality improvement initiatives are implemented within care pathways, flexibility is required to ensure that the measurements which are employed are reviewed and determined as being fit for purpose.

Work to develop a regionally consistent, streamlined system for administrative coding of eyecare services dovetailed with the development of enhanced options for electronic referrals to Ophthalmology via the Clinical Communication Gateway (CCG). The CCG enables tracking of referral activity for specific and identified care pathways. This work is being led by the Health and Social Care Board in conjunction with HSC Trusts and follows on from best practice in the development of coding for other health care specialities.

There is a wealth of data captured in eyecare, as in health and social care. The challenge is to use this data to create knowledge, and use that knowledge to inform the commissioning and planning cycles, understand need, manage performance, reduce variation, and continuously improve quality and outcomes.

An outline Regional Measurement Framework (to enable outcomes-based accountability model) was drafted following a regional workshop in Antrim June 2017 and is included as Appendix 3.



Task Group 3 Chair Mr Martin Hayes leading group work at the Regional Measurement Workshop in Antrim June 2017

Task Group 3 Highlights 2012-2016

At the outset of the DEP Project, Task Group 3 determined four main areas of work which would require particular focus. These were:

- Establish what information is currently available/what is currently measured on eyecare services and what gaps exist, specifically for cataract and glaucoma.
- Establish a baseline to measure the current service provision for cataract and glaucoma, including the monitoring of the COSI activity supporting the glaucoma pathway.
- Benchmark existing service provision across all HSC Trusts for cataract and glaucoma.
- Provide audit data on outputs of the DEP Project in relation to access, clinical outcomes and patient experience with recommendations for ongoing service improvement.

It was necessary to determine and agree the elements of activity and care which would allow Task Group 3 to measure the outcomes. Eight "data capture points", applicable across all care pathways, were agreed:

1. Who is making referral
2. Suspected condition
3. Decision to admit to the service
4. Diagnosis
5. Procedure
6. Clinical Outcomes
7. Measurements of time from start through each stage to finish
8. Patient experience

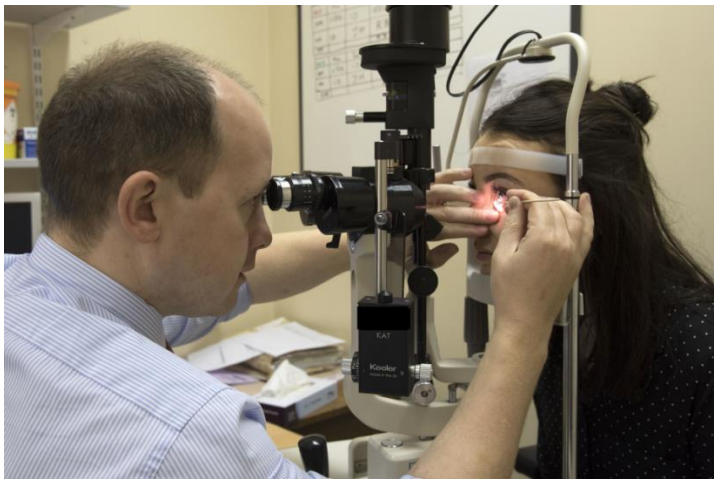
It was agreed that, in terms of measurement, practice at points 3, 4, 5 and 6 was unlikely to change and that the focus would be on points 1, 2, 7 and 8. These four points, together with point 6 are the important DEP Project benchmarks.

6. Task Group 4 - Regional Acute Eye Pathway

DEP 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."

Evidence from one of Northern Ireland's ophthalmology provider Trusts has suggested that as many as 59% of attendances at eye casualty could have been safely and appropriately managed in primary care. Further evidence indicated that around 15% of all outpatient attendances might be similarly managed.

Task Group 4 of Developing Eyecare Partnerships focussed on proposing strategies to deal with acute eye presentations, including which conditions may be safely and appropriately managed in primary care optometry practice.

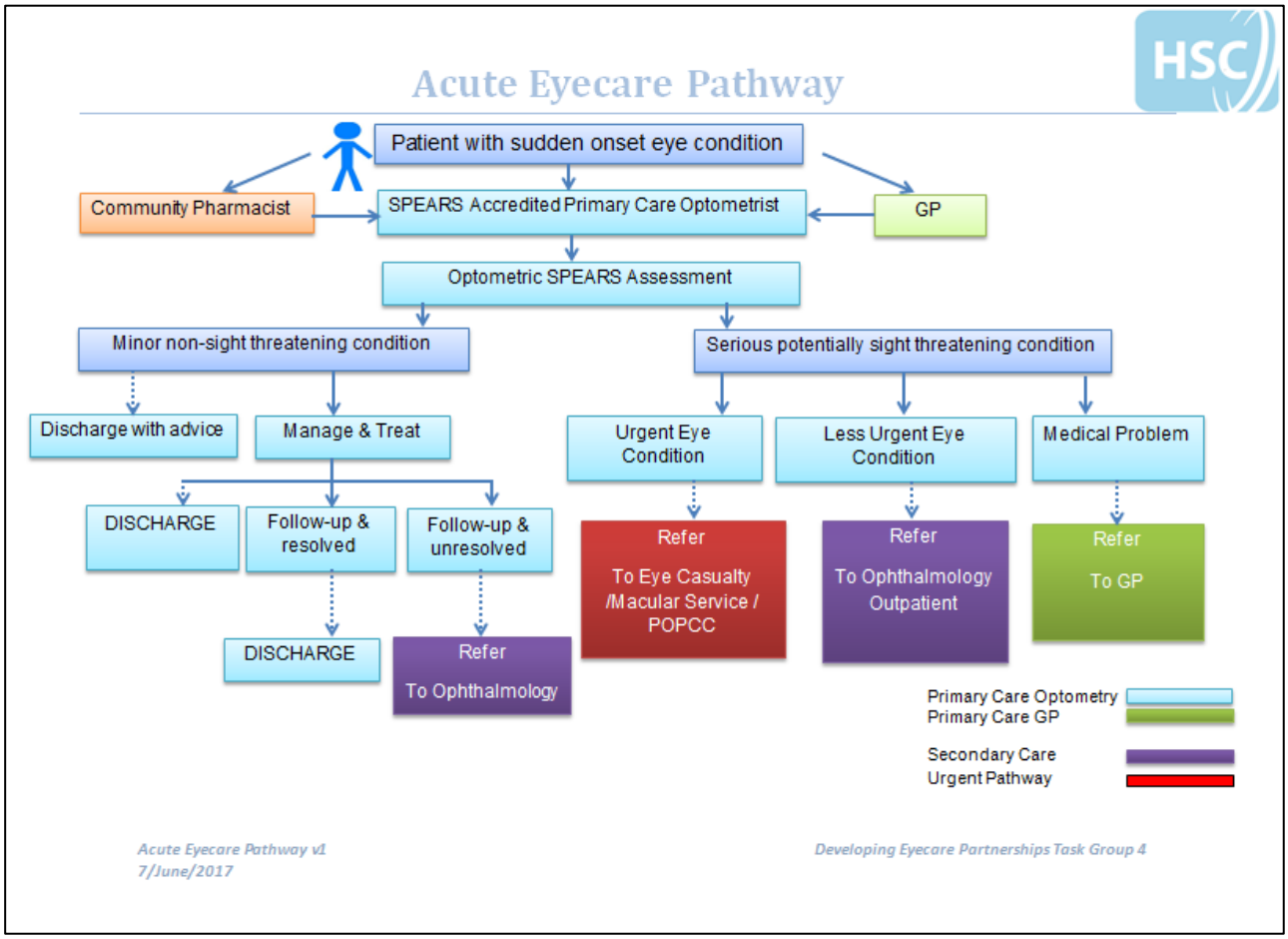


Optometrist Richard Gilmour assesses a patient in WHSCT eye casualty

A pilot primary care optometry led service, the Southern Primary Eyecare Assessment and Referral Service (SPEARS), was launched in the Armagh /Dungannon locality of the Southern LCG area in September 2014 and successfully evaluated in 2016. It was expanded in DEP Year 5 across the Southern LCG area, with 42 of the 46 optometry practices in the area now providing the service. Referrals in and outcomes to date are in line with the pilot. The service involves close working relationships between primary care optometrists, GPs , community ophthalmology and specialist secondary care ophthalmology services.

It is now hoped that the Primary Eyecare Assessment and Referral Service will be expanded throughout Northern Ireland.

Below is the revised NI Acute Eyecare Pathway which was developed in June 2017 by DEP Task Group 4 as a result of the SPEARS pilot.



Task Group 4 Highlights 2012-2016

Southern Primary Eyecare Assessment and Referral Service
The Southern Primary Eyecare Assessment and Referral Service (SPEARS) facilitates the primary care based optometric management of patients with minor non sight threatening acute eye problems. This innovative service aims to reduce demand on secondary care ophthalmology services and enables patients to have access to care for their minor acute eye conditions closer to home.

During the one year pilot, almost 900 patients accessed SPEARS and 81.5 % of these patients, who had minor non sight threatening conditions, were safely and effectively managed by primary care optometrists, consistent with how they would have been managed and treated in secondary care. The remaining 18.5% of patients either had a more serious condition requiring urgent specialist ophthalmology

intervention (12%) or required GP or routine ophthalmology management. The clinical outcomes of the pilot were reviewed and quality assured by Ophthalmology.

The SPEARS pilot demonstrated positive outcomes when evaluated:

- Access to service – 100% of patients accessed care locally within 48 hours
- Clinical safety – benchmarking by a consultant ophthalmologist with special interest in cornea and anterior eye; optometric clinical management: 96.4% agreement
- Patient experience – 87% of patients reported that they were "extremely satisfied" with the service they received

The evaluation included the following recommendations:

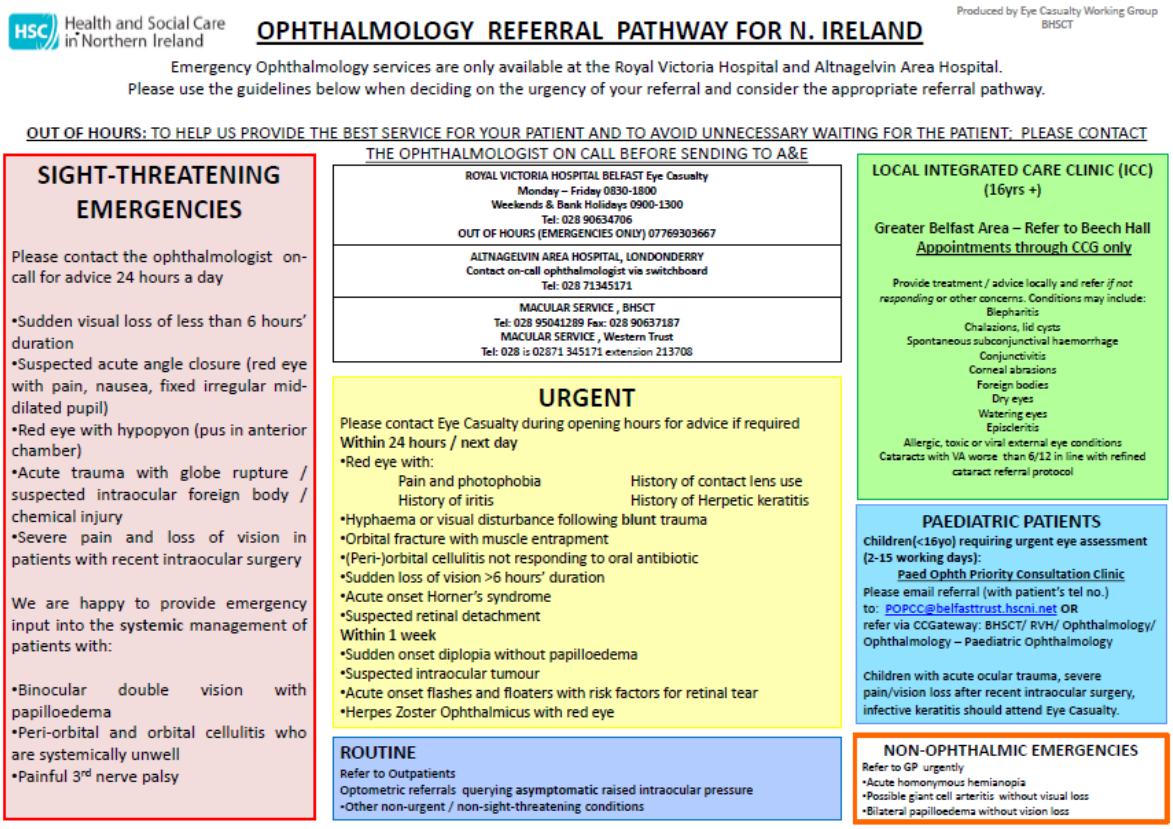
1. SPEARS should be commissioned and rolled out as a permanent eyecare service across the Southern LCG area and the other four LCGs in Northern Ireland.
2. The service should be promoted more widely to encourage patients to attend their optometric practice as their first choice for eye care intervention through: a) Promotion to patients through the Choose Well campaign and local and social media b) Promotion to GPs, GP Federations and community pharmacists through educational events and practice based learning.
3. Further clinical support and training should be provided to the SPEARS accredited optometrists including a peer discussion group, involvement in Project ECHO and attendance at Eye Casualty sessions.
4. Development of the use of IP registered optometrists or a patient group directive would streamline access to treatment and further relieve pressure on GPs.
5. Development of the service to include the management of patients with chronic dry eye conditions in primary care would further relieve secondary care ophthalmology pressures.

Ophthalmology Referral Guidance

An early output from Task Group 4 was the production of Northern Ireland Referral Guidance for Ophthalmic Eye Emergencies, developed to assist primary care optometrists and GPs in determining the level of urgency which should be assigned to an acute eye presentation. The referral guidance provides advice on the ophthalmic conditions which require same day referral and presentations which require urgent and more routine referral. The guidance was issued to all Optometry practices and GP practices regionally and to HSC Trust Emergency Departments

Ophthalmology Referral Advice and Guidance Poster

(This poster can be viewed more clearly by clicking here)



Health and Social Care in Northern Ireland

OPHTHALMOLOGY REFERRAL PATHWAY FOR N. IRELAND

Produced by Eye Casualty Working Group BHSCT

Emergency Ophthalmology services are only available at the Royal Victoria Hospital and Altnagelvin Area Hospital.
Please use the guidelines below when deciding on the urgency of your referral and consider the appropriate referral pathway.

OUT OF HOURS: TO HELP US PROVIDE THE BEST SERVICE FOR YOUR PATIENT AND TO AVOID UNNECESSARY WAITING FOR THE PATIENT; PLEASE CONTACT THE OPHTHALMOLOGIST ON CALL BEFORE SENDING TO A&E

SIGHT-THREATENING EMERGENCIES

Please contact the ophthalmologist on-call for advice 24 hours a day

- Sudden visual loss of less than 6 hours' duration
- Suspected acute angle closure (red eye with pain, nausea, fixed irregular mid-dilated pupil)
- Red eye with hypopyon (pus in anterior chamber)
- Acute trauma with globe rupture / suspected intraocular foreign body / chemical injury
- Severe pain and loss of vision in patients with recent intraocular surgery

We are happy to provide emergency input into the systemic management of patients with:

- Binocular double vision with papilloedema
- Peri-orbital and orbital cellulitis who are systemically unwell
- Painful 3rd nerve palsy

ROYAL VICTORIA HOSPITAL BELFAST Eye Casualty
Monday – Friday 0830-1800
Weekends & Bank Holidays 0900-1300
Tel: 028 90634706
OUT OF HOURS (EMERGENCIES ONLY) 07769303667

ALTNAGELVIN AREA HOSPITAL, LONDONDERRY
Contact on-call ophthalmologist via switchboard
Tel: 028 71345171

MACULAR SERVICE , BHSCT
Tel: 028 95041289 Fax: 028 90637187
MACULAR SERVICE , Western Trust
Tel: 028 is 02871 345171 extension 213708

URGENT

Please contact Eye Casualty during opening hours for advice if required
Within 24 hours / next day
- Red eye with:
  - Pain and photophobia
  - History of iritis
  - History of contact lens use
  - History of Herpetic keratitis
- Hyphaema or visual disturbance following blunt trauma
- Orbital fracture with muscle entrapment
- (Peri-)orbital cellulitis not responding to oral antibiotic
- Sudden loss of vision >6 hours' duration
- Acute onset Horner's syndrome
- Suspected retinal detachment

Within 1 week
- Sudden onset diplopia without papilloedema
- Suspected intraocular tumour
- Acute onset flashes and floaters with risk factors for retinal tear
- Herpes Zoster Ophthalmicus with red eye

ROUTINE

Refer to Outpatients
Optometric referrals querying asymptomatic raised intraocular pressure
- Other non-urgent / non-sight-threatening conditions

LOCAL INTEGRATED CARE CLINIC (ICC) (16yrs +)

Greater Belfast Area – Refer to Beech Hall
Appointments through CCG only

Provide treatment / advice locally and refer *if not responding* or other concerns. Conditions may include:
Blepharitis
Chalazions, lid cysts
Spontaneous subconjunctival haemorrhage
Conjunctivitis
Corneal abrasions
Foreign bodies
Dry eyes
Watering eyes
Episcleritis
Allergic, toxic or viral external eye conditions
Cataracts with VA worse than 6/12 in line with refined cataract referral protocol

PAEDIATRIC PATIENTS

Children(<16yo) requiring urgent eye assessment (2-15 working days):
Paed Ophth Priority Consultation Clinic
Please email referral (with patient's tel no.) to: POPCC@belfasttrust.hscni.net OR refer via CCGateway: BHSCT/ RVH/ Ophthalmology/ Ophthalmology – Paediatric Ophthalmology

Children with acute ocular trauma, severe pain/vision loss after recent intraocular surgery, infective keratitis should attend Eye Casualty.

NON-OPHTHALMIC EMERGENCIES

Refer to GP urgently
- Acute homonymous hemianopia
- Possible giant cell arteritis without visual loss
- Bilateral papilloedema without vision loss

Northern Ireland Formulary: Dry Eye and Glaucoma Prescribing Guidance

In 2015/16, Task Group 4 liaised with HSCB Pharmacy colleagues to agree prescribing guidance for ophthalmic preparations for patients with Dry Eye and Glaucoma. The resultant guidance contained within the **Northern Ireland Formulary for Glaucoma and Dry Eye** provides advice and best practice recommendations in the prescribing for both Evaporative Dry Eye and Aqueous Deficient Dry Eye and Glaucoma.

7. Task Group 5 - Promotion of Eye Health

DEP 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"

DEP OBJECTIVE 2 "Through implementation of Service Framework for Older People, HSC Organisations will offer multi-factorial, evidence based falls and bone health assessments to older people. This will adopt a case management approach for those at high risk of falls, including eyesight tests and enhancement of signposting on access to ophthalmic services in primary and community care."

Smoking and Sight Loss
The work on smoking and sight loss has been continued in partnership with the PHA Tobacco Team. The group explored ways of delivering brief intervention training to a wider audience within primary care and hospital eyecare services. Awareness-raising about the risks of smoking to eye health has been carried out, and is ongoing.

Visual Assessment in Falls Pathways
Links were strengthened with key stakeholder groups and networks involved in falls pathways across primary and secondary care. A draft toolkit for visual assessment was piloted with Falls Services staff.

Early Detection and Treatment of Sight Loss
Task Group 5 worked to raise awareness of the need for the public to have a sight test every two years, to promote good eye health and the need for personal responsibility.

Occupational Eye Injury
A subgroup including the PHA Healthy Workplace Team, PHA communications staff and representatives from the Health and Safety Executive Northern Ireland developed leaflets for employers and employees about prevention of occupational eye injury.

Eye Health Indicators
Task Group 5 reviewed the portfolio of eye health indicators[v] developed by the VISION 2020 UK Ophthalmic Public Health Committee and recommended selected measures to be included in a first annual report.

Learning Disability
Discussions commenced in August 2017, with a range of organisations involved, to explore models of delivery of eyecare services for people with learning disability.

Dementia
Work has been carried out with the Dementia Team to develop a Dementia and Sight Loss leaflet

Eye Heroes
A subgroup was convened in August 2017 to explore the potential of rolling out the “Eye Heroes” initiative across Northern Ireland. This is a children-led public health initiative to prevent avoidable sight loss through the promotion of sight tests to adults by children. It was set up by Moorfields Hospital and has been very positively evaluated.

A Local Lead for the proposed pilot has been identified and registered with the Eye Heroes initiative, giving access to workshop and training material from Moorfields Hospital. The pilot area has been established (Coleraine and Causeway) and several local Optometrists in the Causeway area (all having links with local schools) have been recruited as volunteers.

A video about Eye Heroes may be viewed by clicking here.

In a nutshell

8. Certification of Visual Impairment (CVI)

DEP OBJECTIVE 6b "Pathways for eyecare will ensure that blind/partially sighted certification and registration processes are appropriately conducted."

The CVI process provides an opportunity to collate information about the **incidence** of sight loss in the population. In England, the Public Health Outcomes Framework document **"Improving outcomes and supporting transparency"**[xi], published in August 2016, includes a set of preventable sight loss indicators based on CVI data. Specifically, Public Health England is capturing data on age related macular disease, glaucoma and diabetic eye disease as well as the numbers of people being certified sight impaired or severely sight impaired.

Knowledge of the incidence and nature of sight loss in Northern Ireland is limited and currently there is no regular and consistent means of measuring trends over the medium to long term. There has been a lack of accurate epidemiological data regarding population-based incidence rates of visual loss in Northern Ireland, due to organisational and resource restrictions. Northern Ireland has been reporting a CVI rate of approximately one-third of that occurring elsewhere in the UK.

The pace of demographic change in terms of the ageing of our population, and technological change in terms of new treatment options becoming routinely available, would both suggest that there would be real value in better understanding the incidence of sight loss. Better information would assist service planners across both acute care, social care and integrated care.

While practice has mirrored that in Great Britain over the years, the **legislative basis** for certification and registration is not a specific legislative requirement as in Great Britain. The Department of Health investigated the regulatory basis for certification and confirmed that there was no explicit statutory basis for the form which was being used in Northern Ireland. There are, however, a number of statutory instruments in Northern Ireland which refer to certification of visual impairment as a factor in a person's eligibility for certain benefits, and the requirement that a consultant ophthalmologist is the certifying person is covered in regulations.

The CVI Subgroup have made significant changes to the Northern Ireland form for certification of visual impairment, reviewing and revising both the social care information and the clinical information to be captured as well as the attendant explanatory notes. Issues around patient consent for certification, the capture of anonymised epidemiological data and onward referral to social services were examined and resolved.

The Subgroup also reviewed the pathway of paperwork from clinics, and the referral pathway for patients not eligible for certification from low vision clinics to sensory support was clarified. New and consistent processes for managing the CVI process and paperwork in ophthalmology departments and for the transfer of forms to social services were designed. Some paperwork from the old process which was not deemed to be widely-used or effective was discontinued and a new system for the collation of epidemiological data was developed. New advice and guidance was produced for both HSC staff and patients.

The new CVI process will be launched in late Autumn 2017.

An optometrist uses a Pachymeter in assessing glaucoma

9. DEP Research Group

The DEP Research Subgroup was formed in early 2016. Recognising that planning transformation and modernisation requires a strong evidence base, the research group is a collaborative network drawn from local universities, clinicians and service planners, and builds on established regional translational and clinical research networks. The group benefitted from both academic leadership, and the expertise of locally-based health economist, statistician, medical anthropology and researcher input. Having weighed the benefits of research need, novelty value, ease of data collection and relevance to the DEP Project, the group decided to prioritise three main research agendas:

- **Children's Vision Screening**. The current regional orthoptic-delivered school vision screening programme already enjoys excellent uptake so the group focuses on outcomes: what happens post-screening and is uptake of post-screening intervention therapies equitable, or are targeted interventions required to improve outcomes for all children?

- **Diabetic Retinopathy Screening**. Northern Ireland benefits from a robust regional screening programme, but, like almost all programmes, uptake may be inequitable, with those most in need and potentially marginalised failing to attend for screening. The group looks at ways of maximising uptake, reducing inequalities and building evidence to improve outcomes for all those living with diabetes.

- **Cataract Pathway Review**. Cataract extraction is a successful and life-changing operation, enhancing wellbeing, reducing the risk of falls, and enabling citizens to live independently. There is an element of pathway variation and service provision across centres in Northern Ireland, so the group examines elements of the perioperative pathway and match these to patient experience, choice and outcomes. It is intended that this will be undertaken as a Randomised Control Trial.

SET Extended Scope Orthoptist Mrs Rukhsana McCann with patient Mr Neill Russell in pre and post Cataract assessment

10. DEP 10,000 Voices Working Group

DEP OBJECTIVE 7 (shared with Task Group 3) "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."

Principles of Service Change for Eyecare Services were contained within the DEP Strategy[i]. Services must be outcome-focussed, including a reduction in health inequalities, and success should be measured by improvement in health outcomes and the **patient experience**.

The 10,000 Voices Eyecare Project conducted a SenseMakerAudit® in DEP Year 5 involving users, families, carers and staff from across Northern Ireland to obtain feedback on their experience of hospital eyecare services. Findings and recommendations from the outcome of the survey inform service change, improvements and future development.

Analysis workshops took place in June 2017 and the Group Chair presented on the methodology at the Vision 2017 conference in London.

10,000 Voices Workshop in the Western Health and Social Care Trust in June 2016

In total 531 stories were received from December 2016 – May 2017 during the main period of story collection.

Overall 89% people rated their experience as positive or strongly positive. In these stories, the key messages which appeared to contribute to a positive experience are as follows:

- Being treated with courteous and respect and in a professional manner
- Having access to local services
- Receiving information about what will happen in their care journey and knowing what to expect at clinic appointments
- Receiving treatment which is effective with good outcomes and successful treatments for the patient
- Having consistency in care and being seen and treated by staff with whom patients and their families have developed a relationship

The final report of the 10,000 Voices Eyecare Project will be uploaded to the website for the Northern Ireland 10,000 Voices Initiative in late 2017.

11. Looking to the Future - Recommendations

As with most health economies, Northern Ireland's is continually challenged to meet the needs and demands of the resident population, whilst ensuring safe, accessible and equitable services for all. This is no less true of eye health and care services, which are particularly sensitive to demographic growth (including comorbidities), new and emerging treatments and technologies, the long-term nature of many eye conditions, and increased patient expectations.

As ophthalmology services are, and will remain, high demand and high volume, it is suggested that a **network** be established to integrate sustainable single specialty services. Such a network would understand what best practice looks like for delivering a sustainable network care model which creates and fosters best impact and outcomes for patients, staff and partner organisations.

The network would identify clinical, service and strategic leaders. Patient and user representatives would be equal partners, and fully involved in co-production, and accountability, arrangements. The network would draw on evidence-based needs assessment, workforce planning and clinical and patient outcome measures, and would plan and develop services, being directly accountable to a decision-making oversight board.

The network would require decision-making authority to ensure that services are planned that are responsive, offer safe and timely care, and ensure effective use of resources.

Key elements would be to better understand capacity and capability in both primary care, and secondary care high volume surgery and long-term conditions. This would result in integrated primary and secondary care working, supported by health intelligence, workforce planning and enabling technology.

The general policy and blueprint for health and social care in Northern Ireland is laid out in **Health and Wellbeing 2026: Delivering Together**[ii] This plan has a number of commitments to:

- Address waiting times
- Increase patient self-management services - to enable patients with long term conditions to manage their condition more effectively.
- Expand capacity and capability in primary care - so patients can be appropriately managed locally, outside the secondary care setting.
- Improve direct access between primary and secondary care – to enable more rapid access for patients to secondary care services.
- Reform and modernise secondary care services - to meet patient demand to ensure that patients are seen at the right time, in the right place and by the right person.
- Establish new models of provision such as regional Elective Care and Treatment Centres - to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties.

These principles are consistent with and aligned to the approach adopted by DEP.

As such, the ophthalmic network would be designed to ensure that it delivers the best patient experience and clinical outcome whilst meeting stakeholders' needs. As such, the Northern Ireland Eyecare Network would create a model of high quality, safe, accessible care which is **person-centred, intelligence-based, asset optimised and outcomes focused**.

The Royal College of Ophthalmologists report **"The Way Forward"**[xii], published in January 2017, summarises the likely expansion in demand with between a 20 and 30% increase in workload predicted over the next 10 years for the common ophthalmic conditions of the elderly. These documents indicate how some departments have developed alternative ways of efficient working and are recommended reading for those who have yet to consider such strategies. Many more will need to be equally innovative if the current trend of increasing cases of visual loss as a result of delayed assessments/treatments is to be reversed.

However, the data from the workforce report clearly indicates that the UK urgently requires more ophthalmologists in service. Retaining those already working but approaching retirement will be as important as training new ophthalmologists as more than 20% of the consultants were aged over 55.

As a subsidiary element of DEP, the Health & Social Care Board (HSCB) and Public Health Agency (PHA) have undertaken exploratory discussions around **ophthalmology workforce planning.**
A standard methodology has been described, which seeks to establish standards and principles (based on Royal College, NICE and other guidance). This methodology would develop a template setting out consultant job plans, rotas, and direct clinical sessions and identify current vacancies. It would then look at current trainees, and the attrition rate per sub-specialty. The purpose of the methodology would be to give an evidence base to inform population need in the short, medium and long term.

As such workforce planning for primary care optometry and secondary care ophthalmology services would need to reflect significant developments in service provision, including **the expansion of capacity and capability in primary care (optometry)**, already evidenced in community-based acute eye and glaucoma referral refinement schemes, and **the expanded use of Multi-disciplinary Teams (MDTs) in secondary care**.

Nurse injectors at the Fairview 2 Macular clinic at the Mater Hospital, Belfast, July 2017. L-R Anne Mc Goran, Lisa Konrad, Annamarie Cromie, Cathy Dardis, Dorothy White.

The DEP Project's multi-agency, multi-disciplinary working groups have identified the following set of recommendations for post-DEP priorities for the continued reform of eyecare services in Northern Ireland:

1. Continue to try to progress primary legislation to extend the listing system.
2. Continue to refine, and carry out on a 3 year basis, the Sight Test and Ophthalmic Public Health Survey, and carry out an audit of the referrals from each survey to continue to inform service improvement.
3. Development of an ophthalmic workforce strategy, based on an analysis of gaps and including a training and professional development plan and a quality improvement plan. The focus should be on capacity and capability.
4. Ensure the implementation of the Ophthalmology Common Clinical Competency Framework in Northern Ireland for acute and emergency eye care, cataract assessment, glaucoma and medical retina.
5. Ensure the continued provision of a regional programme of hospital placements for trainee Independent Prescriber Optometrists.
6. Ensure successor network has solid data analytics and direction of travel, with identified outputs, on which to build.
7. Strengthen links with ICPs and GP Federation for pathway improvement.
8. Allocation of recurrent funding for the ECHO® Knowledge Network to deliver OHT monitoring service in primary care practices.
9. Allocation of recurrent funding for a primary care optometry post-operative cataract review and assessment service
10. Primary care based 'refinement' of referrals for wAMD and RVO. Development of a formal process to enable inter-professional collaboration and integrated working Development of new macular pathways and primary care role - 17/18.
11. Continued progression and development of primary care optometry in shared care supported by CCG, NIECR and ECHO®
12. A regional approach / procurement for the ICT supporting infrastructure e.g. Medisoft to ensure equity across region
13. Implementation Committee for the new Regional Measurement Framework for Ophthalmic Services in NI should be established immediately post-DEP.
14. Regional rollout of Primary Eyecare Assessment and Referral Service (PEARS), including work to raise awareness among pharmacies, GPs and the general public.

15. Development of a sustainable NI Ophthalmic Public Health Programme to lead work in the 7 priority areas targeted by Task Group 5: Smoking, Falls, Early detection and treatment, Diabetes, Dementia, Eye injury, Learning disability.
16. N.B. Awareness-raising of eye health is required to be undertaken within existing identified PR campaigns.
17. Establish a regional CVI Oversight Group (post-DEP) to monitor the implementation of the new CVI system and to continue efforts towards establishing an electronic process (CVI to be added to PMS and then to ECR). Explore the potential to introduce legislative change to authorise optometrists to certify visual impairment, as in Scotland. The newly strengthened CVI data will be considered as a primary source of evidence for the indicators for sight loss in the Northern Ireland population which were agreed in 2016 by DEP Task Group 5.

A group of children pictured at the opening of the Children's Eye Unit at Royal Victoria Hospital Belfast on 16th June 2017

12. Conclusion

"If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable."

(Health and Wellbeing 2026)

As the Northern Ireland Programme for Government moves towards a system of Outcomes Based Accountability (OBA) it is important that health and care in general, including eyecare, embraces the same approach. Put briefly we must plan and deliver services which are fit for purpose and which can stand up to scrutiny against:

1. What have we done?
2. How well have we done it?
3. Is anybody any better off?

As of March 17, just short of 25,000 people were waiting for a first ophthalmology outpatient appointment with 18,500 of these waiting over the Ministerial target of nine weeks and just under 7,000 people waiting in excess of one year. Review appointments against clinically-indicated waiting times are similarly challenged, and leave ophthalmology waits within the top four specialties by length.

These figures outline the challenges of dealing with a high demand specialty where ophthalmic primary care is demand-led, and secondary care accounts for 10% of all outpatient demand, and 5% of all HSC surgical demand. Moving towards outcomes-based accountability (OBA) model, creating and offering services which are responsive, offer safe and timely care, and maximise effect use of resources has been the goal of DEP, and will continue to be the focus for any successor network.

We know that there are skills, experience and equipment in optometry primary care that can help to manage that demand, and we also know that more can be done to enable citizens to self-care, and to encourage health promotion and prevention, identifying eye disease at an earlier stage, and improving outcomes.

We further know that care pathways could be improved across primary and secondary care, reducing variations and embedding continuous quality improvement to maximise resource, and to enhance patient experience and outcomes.

The first action listed in **Health and Wellbeing 2026: Delivering Together**[viii] is reducing the lengthy waiting times for elective care treatment in Northern Ireland.

The **Elective Care Plan**[xiii], produced by the Department of Health in February 2017, contains six key commitments and any transformation of ophthalmic services will be in line with these six commitments, listed below:

1. Waiting Times
2. Increase Patient Self-Management Services
3. Expand Capacity and Capability in Primary Care
4. Improved Direct Access between Primary and Secondary Care
5. Secondary Care Reform and Modernisation
6. Establishment of Elective Care Centres

The DEP Project set out in 2012 to improve how eyecare services were commissioned and delivered across Northern Ireland and has achieved a number of successful major pathway transformations. There has been continued growth in patient numbers in eyecare services during the lifetime of the project and yet the 10,000 Voices Project found that 89% of patients rated their experience of eyecare services as “positive” or “strongly positive”, which is a testament to the effectiveness of the reforms, to the quality of the services being provided, and to the skill and dedication of the people providing them.

“Start by doing what’s necessary; then do what’s possible; and suddenly you are doing the impossible.”

(St. Francis of Assisi)

APPENDIX 1: Project Board Membership as at October 2017

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

APPENDIX 2: Task Group Membership as at October 2017

TASK GROUP 1 - Workforce and Legislative Issues

DEP Objective
Objective 3: In order to promote service quality, the DoH 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 Board/PHA working in collaboration with relevant organisations will lead on the implementation of the eyecare strategy. The DoH will lead on any legislative change.

	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	HSCB
4.	Ms Jenny Lindsay	Hospital Eye Service Optometry	BHSCT
5.	Ms Deirdre McAree	Representative	ONI
6.	Mrs Margaret Glass	GOS Legislation (Deputy Principal)	DoH
7.	Mrs Margaret McMullan	Optometric Adviser	HSCB
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

DEP Objectives

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 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.

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Mr Raymond Curran CHAIR	Head of Optometry	HSCB
2.	Mr Alan Marsden	Deputy Commissioning Lead	HSCB
3.	Mr Brian McKeown	Representative	ONI
4.	Mrs Caroline Cullen	Senior Commissioning Manager	HSCB
5.	Mr David Galloway	Director	RNIB
6.	Mrs Emma Herron	Finance	HSCB
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	HSCB
11.	Ms Nicola Kelly	Programme Manager, Service Development & Screening	PHA
12.	Mr Patrick McCance	Orthoptist	BIOS
13.	Mr Paul Cunningham	Commissioning Lead, Specialist Services	HSCB

TASK GROUP 3 - REGIONAL MEASUREMENT

DEP Objective
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.

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Mr Martin Hayes[CHAIR]	Project Director ICP	HSCB
2.	Mr Brian McAleer	Senior Commissioning Manager	HSCB
3.	Ms Adrienne Hull	Eyecare Liaison Officer	RNIB
4.	Mr Asif Orakzai	Ophthalmology	WHSCT
5.	Ms Cathy Gillan	Information, PMSI	HSCB
6.	Ms Cathy Houston	Information Officer	WHCST
7.	Ms Clare Stevenson	Orthoptist	SHSCT
8.	Mr David Mulholland	Ophthalmology	WHSCT
9.	Dr Jackie McCall	Consultant in Public Health	PHA
10.	Ms Jane Hanley	Head of Orthoptic Services	BHSCT
11.	Ms Janice McCrudden	Optometric Adviser	HSCB
12.	Mr David Galloway	Director	RNIB
13.	Dr Jonathan Jackson	Head of Optometry	BHSCT
14.	Ms Katey Gunning	Innovation and Service Development Manager	HSCB
15.	Miss Louise O'Dalaigh	Ophthalmology Acute Services Manager	WHSCT
16.	Ms Lynn Irons	Senior Information Officer PMSID	HSCB
17.	Ms Sorcha Dougan	Patient Access Manager (Out-Patients)	WHSCT
18.	Miss Tanya Moutray	Consultant Ophthalmologist	BHSCT

TASK GROUP 4 - REGIONAL ACUTE EYE PATHWAY

DEP Objective
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*

	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	HSCB
6.	Mrs Emma Herron	Finance	HSCB
7.	Ms Fiona North	Optometric Adviser	HSCB
8.	Ms Jane Hanley	Head of Orthoptic Services	BHSCT
9.	Dr Karen Breslin	Representative	ONI
10.	Mrs Margaret McMullan	Optometric Adviser	HSCB
11.	Mr Matthew Dolan	Pharmacy Co-ordinator (Belfast)	HSCB
12.	Mr Raymond Curran	Head of Optometry	HSCB
13.	Mr Richard Gilmour	Head of Optometry	WHSCT
14.	Sr Rosemary O'Neill	Sister, Eye Casualty	BHSCT
15.	Miss Suhair Twaij	Clinical Lead for Eye Casualty	BHSCT

TASK GROUP 5 - PROMOTION OF EYE HEALTH

DEP Objectives
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 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.

	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	Optometry	BHSCT
6.	Ms Elaine Fitzsimons	Communications	HSCB
7.	Prof. Kathryn Saunders	Education and Research	UU
8.	Dr Mark Holloway	GP with Special Interest	RCGP
9.	Ms Patricia Dolan	Orthoptist	NI Orthoptic Managers' Forum
10	Dr Patrick Hassett	Ophthalmology	WHSCT
11	Ms Rachel Scott	Executive Council Member	ONI
12	Mr Stephen Wilson	Communications & Knowledge Management	PHA
13	Ms Shauna McCrea	Project Manager, Physical & Sensory Disability Strategy	HSCB
14	Dr Damien Bennett	SpR Public Health Medicine,	PHA

CVI SUBGROUP (Reporting to Task Group 5)

DEP Objective
Objective 6b: Pathways for eyecare will ensure that blind/partially sighted certification and registration processes are appropriately conducted.

	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.	Dr Jonathan Jackson	Head of Optometry	BHSCT
5.	Ms Martina Dempster	Senior Social Worker Sensory Services	WHSCT
6.	Miss Tanya Moutray	Consultant Ophthalmologist	BHSCT

10,000 VOICES WORKING GROUP

DEP Objective
Objective 7: There will be high level regional measurements developed to facilitate the monitoring and evaluation of the new eyecare service model and associated pathways. These will include input, output and **outcome** measurements. Data collection will be undertaken in line with data protection principles and information governance. *N.B. DEP Task Group 3 also focuses on DEP objective 7.*

	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	HSCB
9.	Miss Louise O'Dalaigh	Ophthalmology Acute Services 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

DEP Objective
Objective 12a: HSCB/PHA working in collaboration with relevant organisations will lead on the implementation of the eyecare strategy.

	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.	Dr 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 Optometry	HSCB
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

EYE HEROES GROUP (Reporting to Task Group 5 initially, independent following DEP)

DEP Objectives
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. *N.B. DEP Task Group 5 and the Learning Disability Subgroup also focus on DEP Objective 1.*

	NAME	**JOB TITLE/DEPT.**	**ORGANISATION**
1.	Mr David Galloway CHAIR	Director	RNIB
2.	Prof Kathryn Saunders	Professor of Optometry and Vision Science, Subject Head for Optometry	Ulster University
3.	Ms Rachel Scott	Executive Council Member	ONI
4.	Mr David Barnes	Service Delivery Manager	Guide Dogs NI
5.	Ms Julie McClelland	Lecturer in Optometry	UU
6.	Ms Sylvia Ferguson	Chair	NIOS
7.	Ms Hilary Johnston	Health and Social Wellbeing Improvement Manager	PHA

APPENDIX 3: Draft Regional Measurement Framework for Eyecare Services

Outline DEP Regional Measurement Framework – Drafted following Clotworthy House Workshop 16th June 2017

	Measurement(s)	Aspect of Pathway Measured	What does it measure? Quantity, Quality, Outcome?	What information does it provide?	What is missing?	Is this regionally consistent?
1	➢ Number of patients referred ➢ Referrer ➢ Suspected condition	Referral in	Quantity	➢ Numbers of patients ➢ Referral source ➢ Referral reason	➢ Information re. referrals for advice and virtual activity ➢ Origin of referral (if via GP) ➢ 2nd referral not counted as new referral	Yes
2	Time from referral to first outpatient offer	Patient journey	Quantity/quality	Time from referral to first appointment	Weighting of wait times in relation to urgency of referral – recognising the unequal impact of delays on patients (not relevant to Ministerial targets)	Yes
3	Provisional diagnosis at e-triage	Clinical decisions	Quantity	Provisional diagnosis from e-triage		Yes
4	Patient attendance	Patient journey	Quantity	➢ DNAs ➢ Numbers of patients seen	Information on outreach locations offered to patients, and accepted.	Yes
5	Number and type of appointments – new or review	Patient journey	Quality/outcome	➢ Time between appointments ➢ Review backlogs ➢ Delays beyond clinically indicated guidelines		Yes
6	Diagnosis following first attendance	Diagnosis	Quality/outcome	Diagnosis captured on Medisoft	Information on diagnosis would be ideal to inform service planning	Medisoft not consistently implemented across NI
7	Outpatient procedures	Treatment	Quantity/quality	➢ Number of outpatient procedures ➢ Time from outpatient to treatment	➢ No info available as outpatient procedures not coded ➢ Time taken from triage to treatment	Yes
8	Clinical outcome	Clinical effectiveness	Outcome	Clinical outcomes measured on Medisoft. Tight local audit.	Regional collation of local information	Medisoft not consistently implemented across NI
9	Decision to admit	Treatment	Quantity/quality	Number of patients admitted		Yes
10	Patient experience	Patient reported outcome	Quality/outcome	➢ 10,000 Voices stories ➢ Robust patient experience of care, quality and outcomes.	➢ Appropriate quality and quantity of feedback and analysis of it ➢ Experience of patients who are still waiting to access services	Yes
11	Adverse/Serious Adverse incidents	Patient experience/safety	Quantity/quality/outcome	Information on AIs/SAIs is available and is fed into the risk register.	➢ Consistent information – this information is dependent on people reporting the AIs/SAIs ➢ Information on whether the incident related to delays, treatment etc.	Yes

Initial recommendations for actions:

1. Need a consistent clinical patient management system across NI
2. Need to know the impact of quality improvement interventions such as the cataract referral refinement, the reform of the CVI process etc.

Additional Regional Measurements recommended by DEP

	Measurement(s)	Aspect of Pathway Measured	What does it measure? Quantity, Quality, Outcome?	What information does it provide?	What is missing?	Is this regionally consistent?
12	Independent Prescriber Activity in Primary Care	Treatment	Quantity/quality/outcome	None at present	Annual 2-3 month audit of IP Optometrist activity in terms of what abnormal ocular conditions they encounter and treat in Primary Care, to gauge what conditions are being safely assessed and treated in peripheral locations. (Aspect of governance that the College of Optometrists strongly recommends.)	IP activity in Primary Care is regionally consistent

APPENDIX 4: DEP Training and Professional Development Plan

N.B. The timeframes given below relate to the development and initiation phase. TPD to underpin eyecare service reform will continue beyond the lifespan of DEP.

TPD NEED	TARGET GROUP(S)	TIMEFRAME	METHODOLOGY	RESOURCE IMPLICATIONS	OVERSIGHT	ACCREDITATION	PROGRESS/ EXCEPTIONS
Glaucoma							
1 Consultant oversight of training in-house for Glaucoma Clinic Optometrists in the management of stable glaucoma and OHT patients in regional ophthalmology clinics	➢ Ophthalmologists ➢ Optometrists (primary and secondary care) ➢ Nurse Practitioners ➢ Orthoptists	Oct 2014 - Sep 2015	Delivered by Trusts in-house	Funded as part of the agreed IPT	Trust Clinical Lead	Trust-led	Ongoing /Delivered
2 Additional training for Nurse Practitioners and Orthoptists involved in visual fields/OCT			Delivered by Trusts in-house	Funded as part of the agreed IPT	Trust Clinical Lead	Trust-led	Ongoing /Delivered
3 Training for Primary Care Optometrists in the use of eReferral, information governance and relevant IT issues			Training workshops	HSCB, with BSO ITS input	HSCB, eHealth & DoIC	N/A	Achieved and ongoing
4 Training for Glaucoma Clinic Optometrists, Nurse Practitioners and Orthoptists in telemedicine links in regional ophthalmology clinics			Trust in-house	Trust	Trust	N/A	
5 Glaucoma Clinic Optometrists training in the form of the College Higher Certificate in Glaucoma		Oct 2015 – Sep 2016	College-accredited post-graduate provider	Self-funding/Trust	Clinical Lead	College of Optometrists Higher Certificate in Glaucoma	Open/not mandated
6 Primary Care Optometrists additional training and accreditation in enhanced case finding for glaucoma and OHT (Level II Local Enhanced Service)		April 2016 - March 2017	University PG qualification – College of Optometrists Prof Cert in Glaucoma	From existing recurrent LCG funding stream	HSCB/DoIC	College of Optometrists Professional Certificate in Glaucoma	16/17 Achieved, LES II implemented in June 2016.
7 Glaucoma clinic Orthoptists training as indicated by the RCOphth Glaucoma Nov 16, "Common clinical competency framework for non-medical healthcare professionals in secondary care"			University PG qualification	Trust to source via AHP ECG or from existing recurrent LCG funding stream	HSCB/DoIC	BIOS / Optometry accreditation in line with RCOphth glaucoma competency framework Nov 16	16-18
8 Training for Primary Care Optometrists in the use of NIECR. Pilot of NIECR access in primary care optometry practices		Mid-late 2017	eHealth	Minor	ehealth/NIECR SRO	Sign off	eHealth Roadmap 15-17 Pilot Autumn 2017
9 Primary Care Optometrists involved in shared care model for monitoring long term stable glaucoma and OHT patients.		Mid-late 2017	Professional Certificate in Glaucoma and Project ECHO	HSCB	DoIC, HSC Trusts and HSCB ECHO Knowledge Network Lead	College of Optometrists Professional Certificate in Glaucoma	2017 beyond DEP

TPD NEED	TARGET GROUP	TIMEFRAME	METHODOLOGY	RESOURCE IMPLICATIONS	OVERSIGHT	ACCREDITATION	NOTES
Cataract							
1 Involvement of Optometrists, Nurse Practitioners, GPwSI and Orthoptists in sec. care clinic pre-operative cataract pathway.	➢ Ophthalmologists ➢ Optometrists (primary and secondary care) ➢ Nurse Practitioners ➢ Orthoptists ➢ GPs	Oct 2014 - Sep 2015	As per recruitment need/personnel spec	Identified in IPT	Trust	N/A	Ongoing /Delivered
2 Information and guidance for Primary Care Optometrists and GPs in *pre-operative triage* for cataract (pre-operative pathway)		Oct 2014 – Jan 2016	HSCB Guidance	Printing and dissemination of guidance and info absorbed HSCB. 'Cost' of service absorbed by optometrists	HSCB	N/A	Completed 5th Jan 2016
3 Training for Primary Care Optometrists in *post-operative review/care* for cataract (post-operative pathway)	➢ Primary Care Optometrists	2017	Protocols to be developed including audit and QA. In house training by HSC Trusts in line with RCOphth Common Competency Framework (TBA)		HSCB	Training & Accreditation	2017 and beyond
4 Training for nurse practitioners in post-operative cataract review/care	➢ Nurse practitioners	2017	In-house in line with RCOphth Common Competency Framework	Absorbed?	Trusts	N/A	Raised at TG1 Nov 2016
Diabetic Eye Screening Programme							
1 Training for all Optometrists and non-optometrist graders in the Diabetic Eye Screening Programme (DESP) – QA of service requires dedicated time to ensure the optometrist graders have necessary qualifications	➢ Ophthalmologists ➢ Optometrists ➢ Non-optometrist screeners/graders ➢ Technicians	16/17	➢ City & Guilds Qualification ➢ Health Screeners Diploma ➢ ITAP validation modules (online)	Self-funded (contracted) or Trust (employed)	DESP Clinical Lead	2016/17	Achieved
2 Training for all DESP staff in new IT systems to include diagnostics, referrals and links with newly established DMO services				Trust	DESP Clinical & QA Lead	N/A	Achieved and ongoing
Macular Conditions							
1 Training for PC Optometrists and GPs in relation to Current treatments, referral guidelines and pathways	➢ Ophthalmologists ➢ Optometrists (primary and secondary care) ➢ Nurse Practitioners ➢ Technicians	2016/17	Guidance	CPD and Guidance notes	HSCB DoIC	N/A	Achieved and ongoing
2 Training of Technicians as shared resource with DESP							
3 Training of Nurse Specialist Practitioners for macular service		Oct 2014 - Sep 2015	In-house	Identified in IPT	Trust Lead	N/A	Complete
4 Primary Care Optometrists involved in pre-referral filtering and shared care model for monitoring long term stable macular patients.			Professional Certificate in Medical Retina and Project ECHO	Self-Funded	DoIC, HSC Trusts and HSCB ECHO Knowledge Network Lead	College of Optometrists Professional Certificate in Medical Retina	2017 and beyond DEP

TPD NEED	TARGET GROUP	TIMEFRAME	METHODOLOGY	RESOURCE IMPLICATIONS	OVERSIGHT	ACCREDITATION	PROGRESS/ EXCEPTIONS
All Eye Conditions							
1. Brief Intervention Training (BIT) for Primary and Secondary Care Optometrists on smoking cessation 2. Eye care pathways are being reviewed to ensure inclusion of smoking cessation work and to offer brief intervention training to appropriate professionals.	➢ Primary and Secondary Care Optometrists ➢ Appropriate professionals along the eye care pathways	2015-2017	As part of regional Continuing Education and Training (CET) events or as online training.	Smoking and sight loss supporting resources to be developed for optometrists.	PHA	In-house PHA	3 BITs delivered as short evening sessions. Sessions and evaluation ongoing.
Primary Care Optometry Acute Eye Service							
1 Training and Accreditation of PC Optometrists in the triage, treatment and management of acute (non-sight threatening) eye conditions – PEARS in Southern LCG area 2 Training and accreditation of PC Optometrists in other LCG areas where service may be commissioned	➢ Ophthalmologists ➢ Primary Care Optometrists.	Oct 2013 - Sep 2017 2017 and beyond	➢ Online ➢ Didactic ➢ Workshop As Above	Resource needed for training and accreditation As above	HSCB/DoIC HSCB /DoIC	Post-graduate provider Post-graduate provider	Completed March 2017 Dependent of funding of service in other LCG areas
Regional Acute Eye Service (RAES) / Eye Casualty							
1 Development of referral information including protocols for PC GPs, Optometrists and A&E departments regionally on ophthalmic emergencies and PC acute eye schemes.	➢ Ophthalmologists ➢ Optometrists (primary and secondary care) ➢ GPs with Special Interest (GPSIs) ➢ Nurse Practitioners		Poster	Postage and lamination	HSCB	N/A	As above - complete
2 Upskilling of Health Care Assistants to take on some additional duties, as in GB.	➢ Health Care Assistants	Post-DEP	Development of local programmes		Local	Local	Being explored by BHSCT Ophthalmology
Both Primary Care Optometry Acute Eye Service and Regional Acute Eye Service (RAES) / Eye Casualty							
1 Development of referral information including protocols for PC GPs, Optometrists and A&E departments regionally on ophthalmic emergencies and PC acute eye schemes	➢ Ophthalmologists ➢ Optometrists (primary and secondary care) ➢ GPs with Special Interest (GPSIs) ➢ Nurse Practitioners		Poster	Postage and lamination	HSCB	N/A	Complete
Prevention of Sight Loss							
1. Guidance/Training for GOS Optometrists in dealing with patients with learning disability	➢ GOS Optometrists	Post-DEP	TBC	TBC	TBC	TBC	
2. Training for volunteer primary care optometrists in delivering "Eye Heroes" workshops in primary schools	➢ Primary Care Optometrists	Post-DEP	Moorfields Eye Hospital "Eye Heroes" materials	None	Moorfields Eye Hospital with local partnership led by RNIB	Moorfields Eye Hospital	Initial group of volunteer PC Optometrists recruited in pilot area (Coleraine and Causeway)

TPD NEED	TARGET GROUP	TIMEFRAME	METHODOLOGY	RESOURCE IMPLICATIONS	OVERSIGHT	ACCREDITATION	PROGRESS/ EXCEPTIONS
All Settings							
1. Involvement of Independent Prescribing (IP) Optometrists in both primary and secondary care. Promotion of Independent Prescribing (IP) Optometrists and development of a framework for clinical sessions/placements for primary care optometrists	➢ Primary Care Optometrists	Oct 2013 - Sep 2017	Engagement and agreement with Trusts	DoH funded support	HSCB/Trusts	N/A	Achieved and ongoing
2. Updating Eyecare Liaison Officers (ECLOs) on changes to pathways	➢ ECLOs	Post-DEP	Guidance	None	RNIB	N/A	
3. Providing guidance to all involved in the Certification of Visual Impairment (CVI) process on the CVI reforms	➢ Ophthalmologists ➢ Clinic administrative staff ➢ SC and PC optometrists ➢ Sensory Support Teams ➢ ECLOs	Post-DEP	Guidance (including online) and via Continuing Education and Training (CET) events	None	Post-DEP committee (not yet established – see "progress/ exceptions" column)	N/A	A post-DEP CVI Implementation and Oversight Committee needs to be established

APPENDIX 5 - Glossary

A

1. ABDO — Association of British Dispensing Opticians
2. AHP — Allied Health Professions
3. AMD — Age Related Macular Degeneration
4. AOP — Association of Optometrists

B

5. BIOS — British and Irish Orthoptic Society
6. BSO — Business Services Organisation

C

7. CCG — Clinical Communications Gateway
8. CEP — Community Engagement Project
9. CET — Continued Education and Training
10. COSI — Community Optometrist with Special Interest
11. CREST — Clinical Resource Efficiency Support Team
12. CVI — Certificate of Visual Impairment

D

13. DED — Diabetic Eye Disease
14. DESS — Diabetic Eye Screening Service
15. DoH — Department of Health
16. DMO — Diabetic Macular Oedema
17. DNA — Did Not Attend
18. DO — Dispensing Optician

E

19. ECHO — Extension for Community Healthcare Outcomes
20. ECLO — Eye Care Liaison Officer
21. ECR — Electronic Care Record
22. EPR — Electronic Patient Record

F

23. FODO — Federation of Dispensing Opticians
24. FPS — Finance and Procurement System

G

25. GMP — General Medical Practitioner
26. GOC — General Optical Council
27. GOS — General Ophthalmic Services
28. GSL — General Sales List

H

29. HCN — Health and Care Number
30. HES — Hospital Eye Service

31.	HSC	Health and Social Care
32.	HSCB	Health and Social Care Board
33.	HSCT	Health and Social Care Trust
34.	HV	Health Visitor

I

35.	ICATS	Integrated Clinical Assessment and Treatment Service
36.	ICC	Integrated Care Clinic
37.	ICP	Integrated Care Partnership
38.	ICT	Information and Communication Technology
39.	IFR	Individual Finance Request
40.	IOP	Intra Ocular Pressure
41.	IP	Independent Prescriber
42.	IPT	Investment Proposal Template
43.	IS1	Outpatients Independent Sector Activity

L

44.	LCG	Local Commissioning Group
45.	LES	Local Enhanced Service
46.	LMT	Local Management Team
47.	LOCSU	Local Optical Committee Support Unit
48.	LVI	Letter of Visual Impairment

M

49.	MCQ	Multiple Choice Questions
50.	MHRA	Medicines & Healthcare Products Regulatory Agency
51.	MOS	Memorandum of Ophthalmic Services

N

52.	NCT	Non-contact Tonometer
53.	NES	NHS Education for Scotland
54.	NICE	National Institute for Health and Clinical Excellence
55.	NIECR	Northern Ireland Electronic Care Record
56.	NIMDTA	Northern Ireland Medical and Dental Training Agency
57.	NIOS	NI Optometric Society
58.	NMP	Non-Medical Practitioner

O

59.	OCS	Ophthalmic Claims System
60.	OCT	Optical Coherence Tomography
61.	OHT	Ocular Hypertension
62.	OMP	Ophthalmic Medical Practitioner
63.	ONI	Optometry NI
64.	OSF	Ophthalmic Services Forum

P

65.	PAS	Patient Administration System

66.	PC	Primary Care
67.	PCC	Primary Care/Clinical
68.	PMSID	Performance Management and Service Improvement Directorate
69.	POM	Prescription Only Medicine
70.	PSAB	Project Support Analysis Branch (DoH)

Q

71.	QICR	Quality Improvement Cost Reduction
72.	QOAR	Quarterly Outpatient Activity Return
73.	QOF	Quality Outcomes Framework

R

74.	RAES	Regional Acute Eye Services
75.	RCGP	Royal College of General Practitioners
76.	RCP	Royal College of Physicians
77.	RQIA	Regulation and Quality Improvement Authority
78.	RR	Referral Refinement
79.	RVI	Referral of Visual Impairment

S

80.	(S)AI	(Serious) Adverse Incidents
81.	SBA	Service Budget Agreement
82.	SI	Statutory Instrument
83.	(S)PEARS	(Southern) Primary Eyecare Assessment & Referral Service
84.	SR	Statutory Rule
85.	SSCT	Specialist Services Commissioning Team

T

86.	TA	Technology Appraisal
87.	TYC	Transforming Your Care

V

88.	VFM	Value for Money
89.	VIF	Visual Impairment Forum
90.	VPN	Virtual Private Network
91.	VSI	Vision Strategy Implementation

W

92.	WOPEC	Wales Optometry Postgraduate Education Centre
93.	WTE	Whole Time Equivalent

APPENDIX 6 - References

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