DEVELOPING EYECARE PARTNERSHIPS

Improving the Commissioning and Provision of Eyecare Services in Northern Ireland

4TH ANNUAL REPORT

October 2015-September 2016

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DEP: The Regional Context

The 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 vision and aim of the Developing Eyecare Partnerships (DEP) Project is one of an integrated approach to the development of eyecare services in Northern Ireland within a five year timeframe.

"Transforming Your Care – A review of Health and Social Care in Northern Ireland"[ii] (2011) sets out an overarching road map for change in the provision of health and social care in Northern Ireland. It focuses 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 DEP Strategy adopts and follows the Transforming Your Care (TYC) model, and proposed successor models, as a regional strategy, to include local priorities, with access based on clinical need. The DEP Strategy will also ensure skill mixes are optimised to offer better value across pathways, reducing variation and providing better use of resource.

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 vision health, prevent eye disease and have appropriate and timely clinical interventions to maximise sight.

DEP: The National Context

The identification of the need for change is not restricted to Northern Ireland and the UK Vision Strategy 2013-2018[iii] 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[iv] to support review and monitoring of eye health of the population at a national level.

The work of the DEP Project also aligns well with The Royal College of Ophthalmologists’ “Three Step Plan”[v], 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 in England, 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[vi] 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.

The inter-related Community Ophthalmology Framework[vii] was developed by the CCEHC in 2015, and disseminated to Clinical Commissioning Groups.

DEP: The Project Aims

The strategy identified four aims as follows:

1. Identify potential sight-threatening problems at a much earlier stage;

2. 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;

3. 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. Maximise use of HSC resources in both primary and secondary care services.

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

DEP: The Approach

The DEP Strategy aims to provide 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 facilitates 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 will be the use of optimal technologies and seamless communication between those providing the care. The result will be a patient-centred service with emphasis on clinical leadership, training and development giving improved patient experience and outcomes. This, in turn, will provide better value across pathways, reducing variation, and maximising resources.

From the inception of the DEP Project, it was recognised that engagement of stakeholders from all sectors and a multidisciplinary approach to working was essential. The DEP Project continues to develop strategies to underpin what can safely be managed in primary care, use skill mixes and optimise flow in secondary care to build capacity there, identify areas and methodologies where co-managed care and monitoring can be delivered in a community setting, and have support in place for those suffering permanent sight loss. These approaches are to be underpinned by a culture of continuous quality improvement (QI).

DEP: Personal and Public Involvement (PPI)

The active and effective involvement of service users, patients, carers and the public is fundamental to the work to improve commissioning and provision of eyecare services. It is vital that people who access services have input into the planning and decision making process extending beyond the standard processes of consultation. Personal and Public Involvement is integral to the work of the DEP Project, with the needs and values of individuals and families being heard and actively taken into account in the development and improvement of eyecare services.

The DEP Strategy aims to provide accessible opportunities for involvement of service users, patients, carers and the public at all levels ensuring that any identified barriers to engagement are overcome.

The Health and Social Care Board (HSCB) and Public Health Agency, in partnership with service users, patients, carers and the public, will work to consider DEP in the context of:

- **A SYSTEM** – a set of activities with a common set of objectives and outcomes, and an annual report. Systems focus on symptoms, conditions or subgroups of the population
- **A NETWORK** – a set of individuals and organisations that deliver the system's objectives – NOT a team within ONE organisation
- **A PATHWAY** – the route patients usually follow through the network
- **STEWARDSHIP** – to hold something in trust for another.

Patients, service users and carers will be invited to participate in the work of the DEP Project, sharing their experiences and views in regard to eyecare pathways and the promotion of eye health and, in doing so, will provide input and be partners in:

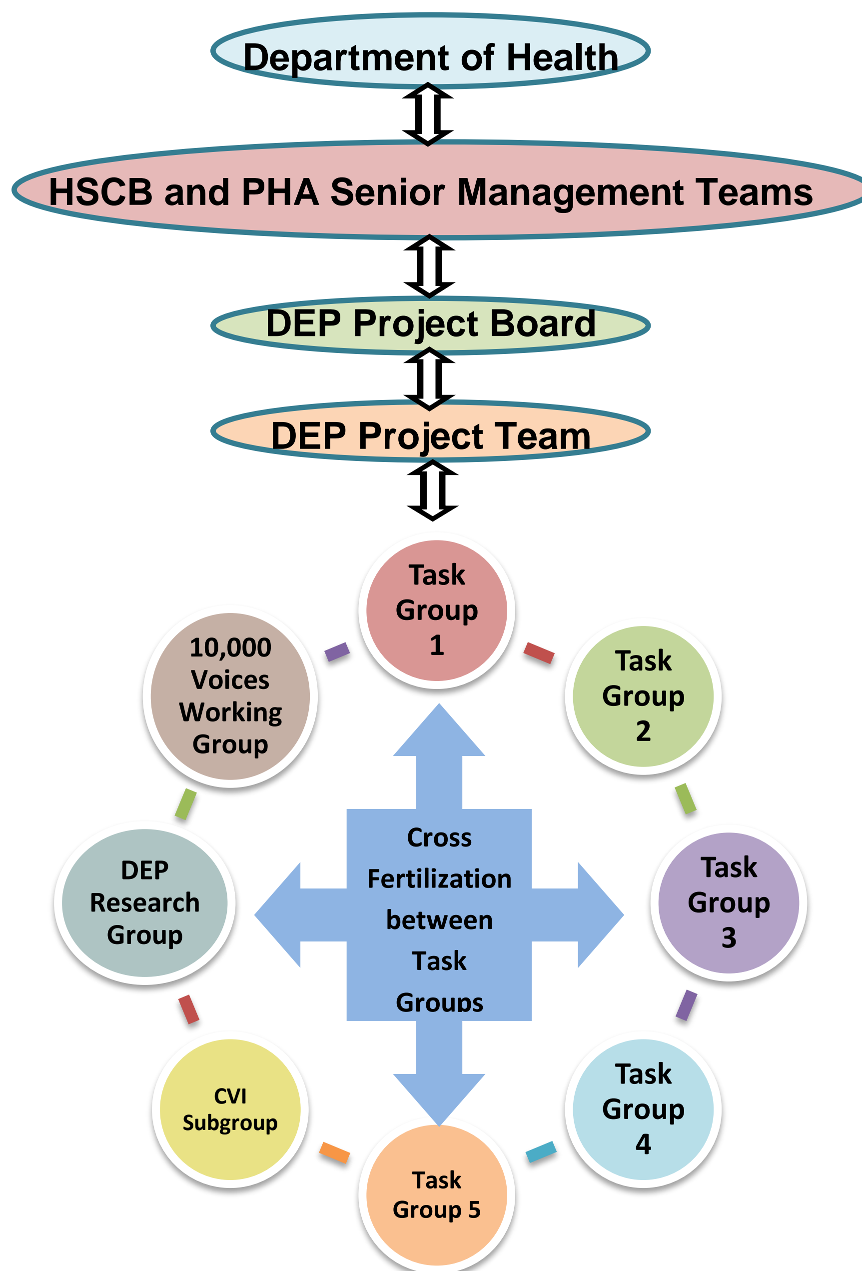
- the planning of eyecare service developments;
- the planning of eyecare service redesign;
- informing quality improvement initiatives in eyecare services;
- advising on the approach to eye health promotion and prevention of sight loss for the public including advancing health literacy in relation to eye health and eyecare services.

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

DEP: The Structure

The DEP Project is sponsored and overseen by the Department of Health (DoH). The Health and Social Care Board (HSCB) and Public Health Agency (PHA) co-lead on the implementation of the strategy over the five year period from 2013 to 2017.

Project management arrangements include dedicated work streams and task groups, each with assigned terms of reference and DEP objectives. The structure of the DEP Project is such that it enables cross-fertilisation of ideas, innovation and work.



Membership of the Project Board is 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. It was recognised that the Project Board should be both dynamic and have the expertise to hold proposed Task Groups to account. Appendix 1 details the membership of the DEP Project Board.

Appendix 2 details the membership of the various project groups.

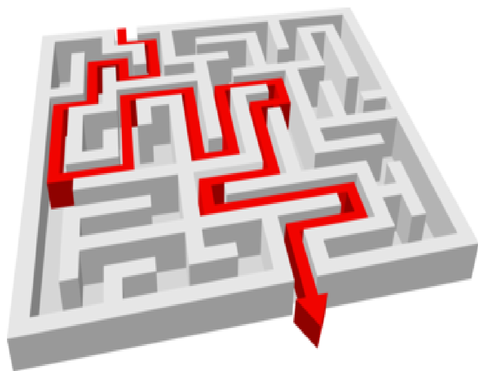
- **Task Group 1** - Workforce and Legislative Issues
- **Task Group 2** - Integrated Models/Pathways
- **Task Group 3** - Regional Measurement
- **Task Group 4** - Regional Acute Eye Pathway
- **Task Group 5** - Promotion of Eye Health

A **Certification of Visual Impairment (CVI) Subgroup** was established in September 2014.

Two further working groups were established in 2015, the **DEP 10,000 Voices Working Group**, which aims to obtain feedback from users and carers on their experience of eyecare services, which will be used to inform service development, and the **DEP Research Group**, which aims to establish a research agenda to inform the development of eyecare services.

Appendix 3 details the DEP groups' Terms of Reference.

DEP: The Project Challenges



The current and on-going financial pressures affecting Health and Social Care, and all areas of the Programme for Government, will continue to be a challenge. The vision of Transforming Your Care[ii] is to see, treat and manage patients and users closer to home, where appropriate. While this can be about reconfiguring how, where and by whom patients are seen within existing resources, additional funding may also need to be identified. It should also be noted that the restructure of health and social care in Northern Ireland may impact on the work and strategic direction of the DEP Project.

Overall, the DEP Project relies on multidisciplinary partnership working. Given current financial pressures, Health and Social Care Trusts are understandably reluctant to release clinical staff for non-clinical engagement activities. The challenge is to create the vision, share the development and build momentum, whilst employing technologies to keep meetings to a minimum.

Additional challenges which relate to specific DEP objectives have been identified within the updates from each DEP Task Group.

Task Group 1 - Workforce and Legislative Issues

Task Group 1 is led by the Department of Health (DoH) and has three objectives relating to legislation, workforce planning and the re-commissioning of 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 ACHIEVEMENTS

Task Group 1 has examined the frameworks which exist in England, Scotland and Wales in order to determine the best regulatory framework for 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 which is now enacted.

This Memorandum refers to the Health (Miscellaneous Provisions) Bill as introduced in the Northern Ireland Assembly on 30 November 2015, (Bill 72/11-16)

HEALTH (MISCELLANEOUS PROVISIONS) BILL

EXPLANATORY AND FINANCIAL MEMORANDUM

THE NEXT STEPS

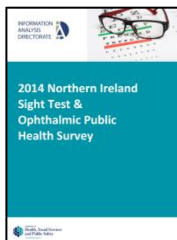
The Department of Health and Health and Social Care Board have worked together to agree amendments to the current GOS Regulations with the aim of improving governance and quality assurance processes and the administrative management of GOS. Draft amending Regulations have been sent to DoH legal advisers and full consultation on the amended Regulations is planned for late 2016/early 2017.

The current work to reform the structures for Health and Social Care commissioning and provision will inform the options and possibilities which Task Group 1 will examine in order to address Objective 3. The legislative oversight of GOS provision in the future, including the work to address Objective 3, will remain a priority for Task Group 1.

THE CHALLENGES

The challenges faced by Task Group 1 relate to the current process to reform HSC in Northern Ireland. Work to address Objective 3 requires enabling amendments to primary legislation. This cannot take place until the new structures and arrangements are in place, following reform, and it is 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."



Task Group 1 developed and delivered an added-value Northern Ireland Sight Test and Ophthalmic Public Health Survey[viii] 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 will inform service planning and provision. As an outcome of the 2014 survey, the Department of Health supported and committed to the delivery of the Survey again in 2017. 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.

THE ACHIEVEMENTS

In early 2016, the Department of Health, in collaboration with the Health and Social Care Board, initiated the planning for the 2017 Northern Ireland Sight Test and Ophthalmic Public Health Survey. At 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. Following consultation and feedback from across all the DEP Project Task Groups, the survey questions were agreed and presented to the DoH Information and Analysis Department who will deliver the Survey.

Ophthalmic activity in relation to GOS provision has been examined in order to stratify the sample of participating optometry practices and optometrists therein. It is anticipated that the survey will take place over a four week period towards the end of January 2017 and, at the time of this report, options are being considered as to how an electronic web-based survey might be facilitated.

THE NEXT STEPS

Planning will progress to ensure successful delivery of the 2017 Northern Ireland Sight Test and Ophthalmic Public Health Survey. All data from the survey will be analysed and a report generated on the outputs. It is anticipated that the Survey report would be available by the summer of 2017 and would be presented to the DEP Project Board.

THE CHALLENGES

Challenges in the delivery of Objective 4 have been managed well and have related primarily to the difficulties with IT and the communications with independent optometrists who do not have access to a 'managed network' supported by Health and Social Care. Challenges exist in relation to the issuing and receipt of survey information electronically to a large number of non-HSC email addresses and the hosting of a database by the Department of Health containing survey return information.

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.”

TASK GROUP 1

In order to address Objective 10, Task Group 1 have supported the development of a DEP Training and Professional Development Plan to identify the elements of workforce development which are necessary to deliver on the reform and integration agenda of DEP, particularly the training and development needs identified by Task Groups 2 and 4, who are charged with eyecare pathway development and re-design.

THE ACHIEVEMENTS

During 2015/16, work has been ongoing to deliver training and professional development within the multi-disciplinary workforce involved in the following care pathways, aligned to the needs identified in the training and development plan:

- Acute Eye Pathway (Objective 9, Task Group 4)
- Glaucoma Pathway (Objective 6a, Task Group 2)
- Cataract Pathway (Objective 6a, Task Group 2)
- Macular Pathway (Objective 6a, Task Group 2)
- Diabetic Eye Screening Pathway (Objective 6a, Task Group 2)

Multidisciplinary Team working in the Glaucoma Service, Belfast Health and Social Care Trust

In addition, Objective 10 specifically references the “promotion of independent optometrists’ prescribing, where appropriate to do so.” During 2016, the Department of Health and representatives of the Health and Social Care Board (HSCB) have progressed work to address the requirement.

The following achievements are noted:

- Registration of Independent Prescribing (IP) Optometrists with the Health and Social Care Board to enable issuing of HS21 prescriptions by primary care IP Optometrists. At the time of this report nine optometrists are providing HS21 prescriptions in primary care for patients who require ophthalmic medications and preparations.
- A patient experience and outcome survey of patients accessing IP Optometrists was initiated in May 2016. During 2017, the HSCB will review and analyse the feedback from survey returns.
- Agreement has been reached with the Belfast and Western Health and Social Care Trusts to develop a framework of clinical placements for IP Optometrists-in-training to facilitate equitable and on-going access to mandatory clinical experience for optometrists. The placements will be available in the Western Health and Social Care Trust initially at the end of September 2016 and in Belfast Health and social Care Trust towards the end of 2016/early 2017.
- A business case has been submitted to the Department of Health to secure recurrent funding to support the provision of IP clinical placement sessions annually for up to 12 optometrists. At the time of this report, early indications are that this business case will be successful in securing the necessary financial resource.

THE NEXT STEPS

Building on the successes and achievements of 2016, Task Group 1 will continue to examine how Objective 10 can be addressed, in particular how Clinical Leadership can be promoted and embedded within services and care pathways. Task Group 1 will examine the role of Quality Improvement (QI) and how it can influence change and reform of eyecare service provision. Further work to support the training and development needs identified by DEP Task Groups will be undertaken.

THE CHALLENGES

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 will be required to be innovative in their approach to ensure that Objective 10 can be fully delivered.

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 6 "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."

The consultation prior to publication of the DEP Strategy[i] 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."

As noted on page 4 of this report, this approach is not unique to Northern Ireland. Other health economies in the UK and worldwide are taking a skills-mix and pathway approach to maximising resources. This should ensure that all members of the wider ophthalmic team work (safely) to the top of their licenses to ensure that patients and service users enjoy better access, modern technologies and improved quality and outcomes in inclusive delivery of eyecare services.

Delivery on Objectives 5, 6a and 8 tests 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 ACHIEVEMENTS

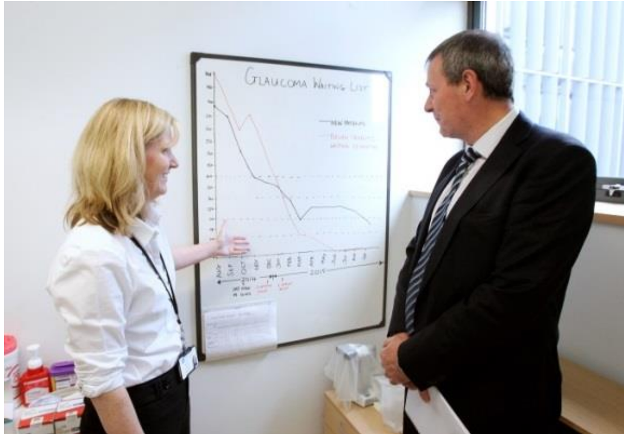
2016 witnessed consolidation of pathway redesigns for the "long term conditions" and cataract, creating a better understanding of capacity and demand for local and regional services.

The **Glaucoma/Ocular Hypertension (OHT)** pathway continued to benefit from primary care demand management by "repeat measures" refinement, and 2016 also saw the introduction of glaucoma/OHT "advanced case finding" in primary care, helping to ensure that only those patients who require secondary care services are directed to these. The repeat measures local enhanced service continues to reduce referrals into secondary care by 65%. Advanced case finding will build on this where it is safe and appropriate to do so.

UK Vision 2015 – Poster Prize Category Winner: Primary Care Optometry Local Enhanced Service

Once referred to secondary care, new models of care ensure that outcomes and experience are maximised, using the mix of skills available to deliver clinician-led one-stop services.

Waiting times in the Glaucoma Service in Belfast Health and Social Care Trust have been reduced as a result of direct investment, and service re-design and partnership working has facilitated direct benefit for patient care.



BHSCT glaucoma lead Dr Angela Knox demonstrates the impact of QI initiatives in the glaucoma care pathway to Department of Health Permanent Secretary Richard Pengelly

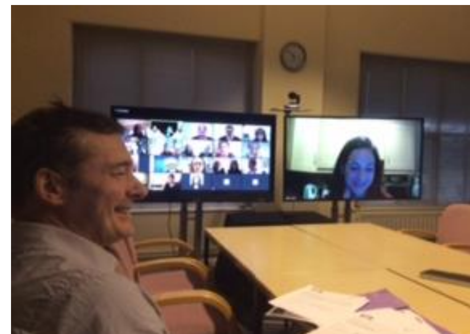
In the **Macular Service** (including wet age-related macular degeneration, retinal vein occlusion and diabetic macular oedema), a new rapid-access referral protocol has been agreed and implemented regionally, ensuring that signs and symptoms are accurately recorded and that patients are involved in 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. Planning is underway to establish outreach diagnostic and treatment clinics for macular services in a number of locations. Initiatives on re-configuring the flows and streams of macular service provision, in addition to the development of the extended role of Nurse Injectors, have resulted in Belfast Health and Social Care Trust's Macular Service being shortlisted for a 2016 Chairman's award.

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 will help to ensure that uptake of screening for all eligible people is maximised and those suspected of having **diabetic retinopathy** have timely access to treatment.

Cataract continues to be a high demand procedure (8115 cataract extractions in NI in 2015/16), the most common and safest surgical procedure worldwide, and arguably one which contributes most to empowering citizens to live safely and independently. 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 also 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[ix] report was produced by Northern Ireland Hospice in May 2016.

The recent 15/16 evaluation report on NI Echo 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



Glaucoma /Macular ECHO Knowledge Network:"Moving Knowledge, Not People"

THE NEXT STEPS

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.

In 2017, the DEP Project will develop these strategies, and continue to progress community-based post-operative cataract care. Quality assurance and audit will be 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 will develop 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.

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, about 30,000 referrals in 15/16. 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.

THE ACHIEVEMENTS

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) will revolutionise both the referral and the feedback process, helping to manage demand and improving patient safety.

At the time of printing this annual report, the first cohort of optometry e-Referrers are about to “go live”. Decision-making aids on CCG (banners), referral templates and the ability to track and receive feedback from a referral will enhance the patient pathway, and open doors for innovative technologies such as eTriage, “referral for advice”, and telemedicine and monitoring.

The same portal technology will also support GOS access to the secure HSC email system.

THE NEXT STEPS

The DEP Strategy considers the potential for ICT developments to be transformative. Improved communication, telemedicine links (including “referral for advice”), eTriage and technologies such as Project ECHO© will be further developed so as to fully realise this potential.

THE CHALLENGES

As with all health economies, the main challenges to successfully improving the planning and delivery of high quality eyecare in Northern Ireland are demographic. Coupled with the costs associated with new and emerging treatments and heightened patient expectations around access and outcomes, the welcome consequences of patients and service users living longer puts pressure on safe and effective delivery of quality health and social care. This is particularly true of ophthalmic care as many of the long-term conditions present more with advancing age.

All providers can work harder, or they can work smarter by working together, and DEP Task Group 2 will continue to work within demographic and financial constraints to deliver that care in 2017 and beyond.

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.

THE ACHIEVEMENTS

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. This will include 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 will be the important DEP Project benchmarks.

THE NEXT STEPS

Task Group 3 has been advised that capability exists to record and analyse information for the eight identified data capture points.

A regionally consistent, streamlined system for administrative coding of eyecare services is now emerging. This work has dovetailed with the development of enhanced options for electronic referrals to Ophthalmology via the Clinical Communication Gateway (CCG) which will enable 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.

Within the structure of the DEP Project, it is noted that there is cross-over and interdependency in this work with Task Group 2(DEP Objective 11). Task Group 3 will now examine the options for the generation of reports collating data from the “patient journey” within care pathways and determine the optimum mechanisms and routes whereby these reports can be generated and analysed.

THE CHALLENGES

Challenges exist in the delivery of DEP Objective 7 as the information required to adequately evaluate outcomes is dependent on data quality, with reliance on the accurate and robust recording of data from the point of referral to the point of treatment and/or discharge, including the essential steps to record patient experience.

DEP 10,000 Voices Working Group

DEP OBJECTIVE 7 (shared with Task Group 3 above) "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 aims to undertake a SenseMakerAudit® for eyecare services involving users, families, carers and staff from across Northern Ireland to obtain feedback on their experience of eyecare services.

Eyecare services are delivered for the population of Northern Ireland by the Belfast and Western Health and Social Care Trusts. Findings and recommendations from the outcome of the audit will inform service change, improvements and future development.

THE ACHIEVEMENTS

10,000 Voices in action at pilot in Western Health and Social Care Trust Ophthalmology Workshop

A project working group was established in early 2016 and a project plan agreed. A draft survey tool was developed, piloted and evaluated during July-August 2016.

The 10,000 Voices working group aims to launch the survey across secondary care in autumn 2016 and it is hoped that the findings and outcomes of the survey will be available in early 2017.

TASK GROUP 4 - Regional Acute Eye Pathway

TASK GROUP 4

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."

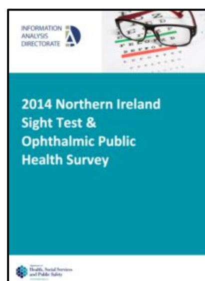
The work to address DEP Objective 9 is multi-faceted, adopting the following approach:

- ❖ assessing, triaging and managing patients within primary care optometry who present with non-sight threatening eye conditions, ensuring that only those who need to be assesses in secondary care are referred;
- ❖ streamlining of the referral pathway and the creation of clear referral guidance;
- ❖ investment in the clinical workforce within Belfast Health and Social Care Trust Eye Casualty, including optometrist clinical sessions.

THE ACHIEVEMENTS

2015/16 realised several key milestones and achievements for Task Group 4, including the evaluation of the pilot service for 'acute eye' in the Armagh & Dungannon locality of the Southern Local Commissioning Group (LCG) area and the publication of formal Northern Ireland Formulary prescribing guidance for Ophthalmic Preparations for Dry Eye and Glaucoma.

Southern Primary Eyecare Assessment and Referral Service (SPEARS)



"SPEARS" was launched as in September 2014 as a one year pilot to facilitate the primary care based optometric management of patients with acute eye problems. This innovative service aimed to reduce demand on secondary care ophthalmology services by enabling patients to access care for their eye condition closer to home.

During the one year pilot, almost 900 patients accessed SPEARS and 81.5 % of these patients were safely and effectively managed by primary care optometrists, consistent with how they would have been managed and treated in secondary care. The outcomes were reviewed and quality assured by Ophthalmology.

The SPEARS pilot demonstrated positive outcomes when evaluated:

- Access to service – 100% of patients accessed care within 48 hours
- Clinical safety - benchmarking with consultant ophthalmologist with special interest in cornea and anterior eye optimum management plan: 96.4% agreement
- Patient experience – 87% of patients reported that they were “extremely satisfied” with the service they received

In late autumn 2015, I woke with a sore, very swollen, dark red eye which was barely open and very sticky. I did not know where to go, it was a Sunday so I duly went to the A&E unit at the Mater Hospital where I was prescribed eye drops and advised that if my problem was not any better by the following morning that I should attend Eye Casualty in RVH. The following morning I went to Eye Casualty and was advised I had conjunctivitis and prescribed antibiotics to treat it. I followed the instructions and in addition attended my GP about the problem.

Two weeks later the conjunctivitis in the same eye reoccurred and my other eye had slight infection and I went back to see my GP who did not examine or assess my eyes (due to lack of equipment) but prescribed some more of the same antibiotics and I was advised to take time off work as I was unable to see properly

I rang my local optometrist and was able to get an appointment within 24 hours. The optometrist examined my eyes thoroughly, he put my mind at ease immediately by a test which told him it was a viral infection. He put in place a regime for treatment and management which included cream to apply directly to the eye and Systane® lid wipes and eye drops for cooling the eye. He also arranged two follow up assessments.

I can say positively that all the health care professionals who treated me were very helpful and considerate but the cost to HSC was excessive and I utilised services which were not best suited to my need at that time. I now know that my optometrist was the person best placed to help me in the first instance and that he has the necessary skill and knowledge to have assessed my condition and managed it appropriately – safely and effectively in a convenient location at a time that suited me.

If a service to assess and manage patients with minor eye problems was available and was properly signposted (such as the HSC Choose Well campaign does) then I feel that patients would benefit from receiving safe and appropriate care closer to home with all the positive experience that that would provide.

SPEARS Patient

Ophthalmology Referral Guidance

During 2016 TG4 were pleased to receive and recommend for regional use referral guidance for ophthalmic eye emergencies drawn up by Belfast HSCT. The Ophthalmology Referral Pathway guidance was 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.

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.

Belfast Health & Social Care Trust Eye Casualty

BHSCT has reconfigured and modernised Eye Casualty which includes the resourcing clinical sessions for optometrists. Optometrists have the core skills and knowledge to triage, assess and manage a cohort of patients who present to Eye Casualty. The additionality of qualification in independent prescribing (IP) which these optometrists have will be of key importance in allowing the Optometric Staff to manage patients independently where appropriate.

THE NEXT STEPS

Task Group 4 will continue the work to progress the regional implementation of a Primary Eyecare Assessment and Referral Service and support the Health and Social Care Board in their endeavours to secure recurrent funding for the service on a regional basis.

THE CHALLENGES

As noted in the work of DEP Task Group 2, challenges exist in relation to availability of funding to deliver a regional pathway for the acute eye corroborated with evidence from the SPEARS pilot. The Health and Social Care Board will continue present the rationale and submit the necessary business cases to progress the full implementation of DEP Objective 9.

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."

THE ACHIEVEMENTS

1 **Smoking and Sight Loss**
The work on smoking and sight loss has been taken forward in partnership with the PHA Tobacco Team. Two smoking cessation brief intervention training sessions were delivered to primary care optometrists in November 2015 and June 2016 and positively evaluated. The group is currently exploring ways of delivering brief intervention training to a wider audience within primary care and hospital eyecare services. Task Group 2 is reviewing pathways to ensure smoking cessation is included. Supporting patient information materials are currently being developed.

2. **Visual Assessment in Falls Pathways**
Links have been created with key stakeholder groups and networks involved in falls pathways across primary and secondary care. A draft toolkit for visual assessment is currently being piloted with Falls Services staff and arrangements are being established as part of this to signpost to optometry services.

3. **Early Detection and Treatment of Sight Loss**
Within this area Task Group 5 has been trying 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. To support this, the group has developed a calendar of annual media opportunities such as World Sight Day and National Eye Health Week and has developed messages around specific topics such as smoking and sight loss, and diabetes and eye health. A video has been developed and uploaded to the Health and Social Care Board website to show what is involved in an eye examination. Click here to view the video.

4. **Occupational Eye Injury**
A literature review was undertaken focussing on the epidemiology and risk factors for occupational eye injury, and effective preventative measures. A subgroup including the PHA Healthy Workplace Team, PHA communications staff and representatives from the Health and Safety Executive Northern Ireland are working on draft leaflets for employers and employees about prevention of occupational eye injury.

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

THE NEXT STEPS

In 2017, Task Group 5 aims to:

- Progress roll-out of brief intervention training to eyecare staff;
- Continue to raise public awareness about eye health issues;
- Promote personal responsibility, including risks of smoking to eye health;
- Evaluate the visual assessment tool for Falls Service staff;
- Finalise an occupational eye injury leaflet and work with relevant sectors to raise awareness;
- Map out services available for detecting eye health problems amongst those with a learning disability;
- Collate data for an eye health indicator report.

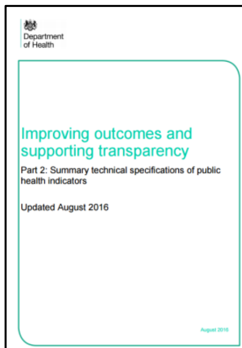
THE CHALLENGES

A recent report commissioned by the General Optical Council (GOC) in 2015, Public Perceptions of the Optical Professions[x], illustrates perceptions as to what is available on the high street. The GOC was presented with findings from survey which showed that people in the devolved nations of the UK were more likely than those in England to visit an optician if they had an acute eye problem. 31% of Scots would first visit an optician if they woke up with an eye problem compared to 26% in Wales, 25% in Northern Ireland and just 18% in England. The survey indicates that, whilst perceptions are changing as primary care optometry embraces “eye care” as well as “eye wear”, more must be done to address the barriers, perceived or real, that dissuade citizens from visiting an optometrist. Awareness-raising of eye health is required to be undertaken within existing identified PR campaigns. That eye health has not been identified as a priority area for such campaigns remains a challenge.

Certification of Visual Impairment (CVI) Subgroup

CVI SUBGROUP

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



Understanding the Incidence of Sight Loss

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.

The Legislative Position

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 DEP CVI Subgroup is seeking to have the statutory basis of certification in Northern Ireland resolved by its inclusion in future primary legislation on health and social care but this is dependent on the views of the Minister and Department.

ACHIEVEMENTS

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. Epidemiological analyses of the CVI forms submitted in 2014 and 2015 were carried out, with the 2014 analysis presented to Divisional Audit meeting.

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.

> “Having coordinated the collection and collation of all new severe sight impairment (Blind Register) and sight impairment (Partially Sighted Register) for over 15 years, it is really exciting to see real and genuine cross-professional and inter-agency interest evolving in the area of certification and registration. It is so important in developing plans for services for vision impaired persons to have a clear understanding of the true incidence and prevalence of sight threatening eye disease. Sight loss has such a profound impact on quality of life, in the educational, employment and social spheres, that we cannot afford not to have adequate detections and serious sign-posting processes in place. In 2017 we should have a new, fit-for-purpose certification form and process in place for adults and children and should be in a better position to ensure that all of those who will benefit from certification avail of it. This will also assist with even more useful epidemiological data on the incidence of sight loss in Northern Ireland.”
>
> Professor Jonathan Jackson, Head of Optometry, Belfast Health and Social Care Trust and DEP CVI Subgroup Member

THE NEXT STEPS

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.

DEP Research Group

"…all others bring data" (Edwards Deming)

Although not aligned to a specific DEP Objective, 2016 witnessed the formation of a Research Subgroup, under the direction of DEP Project Board member Professor Congdon. 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 will benefit 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 has 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 will focus 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 will look at ways of maximising uptake, reducing inequalities and building evidence to improve outcomes for all those living with diabetes.
- **Cataract Pathway Review**. We know that cataract extraction is a successful and life-changing operation, enhancing wellbeing, reducing the risk of falls, and enabling citizens to live independently. We also know that there is an element of pathway variation and service provision across centres in Northern Ireland, so the group will examine 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.

The DEP Project Board looks forward to the evidence base which the Research Subgroup will bring to the overarching DEP transformation agenda.

Conclusion

As of June 2016, just short of 20,000 people in Northern Ireland were on the waiting list for a first ophthalmology outpatients appointment, with just over 3,000 waiting more than one year. Whilst this is an improvement on 15/16, 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, and 5% of all HSC surgical demand.

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 DEP Project has already delivered successes in improving access and outcomes around glaucoma and macular care, and this "whole pathway" approach should be replicated at scale. Optimising resources, including full utilisation of skills mixes, are central to this modernisation and reform. Involving patients and carers in pathway redesign, co-producing systems change, is also crucial, and an ongoing 10,000 Voices initiative around eyecare services should do much to inform, re-shape and put the patient at the centre of their care.

It is hoped that this annual report outlines these successes to date and plots the next steps in turning the DEP strategic vision into mainstream reality. Transformation requires change, innovation and reinvention. It also requires an element of risk-taking, but these risks must be managed with outcomes-based data used to drive decision-making: from SPEARS to glaucoma remodelling, smoking cessation to macular treatments, innovation and transformation should be guided by the mantra, "Is it safe enough to try, is it good enough to start?"

The DEP Strategy does not exist in isolation and aligns to both national and international healthcare reform initiatives, and local modernisation around outpatient and elective care reform.

As Minister O'Neill prepares to unveil her vision and blueprint for health and social care, the Developing Eyecare Partnerships Project Board remains confident that the coordinated approach to disease prevention and improving outcomes, reducing inequalities and maximising

resource, will ensure that citizens should enjoy timely access to services and treatments enabling them to live safely and independently.

In addition to the ten principles of service change laid out in the DEP Strategy[i], the DEP Project relies on five building blocks for transformation:

- Strategy and Culture
- Staff and user engagement
- Process and Innovation
- Enabling Technology
- Data and Analysis

Partnership is key, and collaboration essential. We look forward to continuing this work in 2017 and beyond.

"Strategy is a style of thinking, a conscious and deliberate process, an intensive implementation system, the science of ensuring future success."

Pete Johnson

Appendix 1: Project Board Membership as at October 2016

	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.	Mr Dean Sullivan	Director of Commissioning	HSCB
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	HSCB
13.	Prof. Kathryn Saunders	Professor of Optometry and Vision Science, Subject Head for Optometry	UU
14.	Miss Louise O'Dalaigh	Ophthalmology Acute Services Manager	WHSCT
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.	Ms Sharon Gallagher	Director of Service Delivery	DoH
22.	Prof. Usha Chakravarthy	School of Medicine, Dentistry & Biomedical Sciences	QUB

Appendix 2: Task Group Membership as at September 2016

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	HSCB
4.	Ms Jenny Lindsay	Hospital Eye Service Optometry	BHSCT
5.	Dr Karen Breslin	Chairperson	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

APPENDIX 2

	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
14.	Mr Stephen Boyd	Clinical Services Manager	BHSCT

APPENDIX 2

TASK GROUP 3 - Regional Measurement

	NAME	JOB TITLE/DEPT.	ORGANISATION
1.	Mr Brian McAleer CHAIR	Senior Commissioning Manager	HSCB
2.	Ms Adrienne Hull	Eyecare Liaison Officer	RNIB
3.	Mr Asif Orakzai	Ophthalmology	WHSCT
4.	Ms Caroline Earney	Senior Information Officer, PMSI	HSCB
5.	Ms Cathy Gillan	Information, PMSI	HSCB
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	HSCB
11.	Mr David Galloway	Director	RNIB
12.	Prof. Jonathan Jackson	Head of Optometry	BHSCT
13.	Ms Katey Gunning	Innovation and Service Development Manager	HSCB
14.	Miss Louise O'Dalaigh	Ophthalmology Acute Services Manager	WHSCT
15.	Ms Lynn Irons	Senior Information Officer PMSID	HSCB
16.	Mr Martin Hayes	Project Director ICP	HSCB
17.	Dr Sonia George	Ophthalmology	BHSCT
18.	Miss Tanya Moutray	Consultant Ophthalmologist	BHSCT

APPENDIX 2

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	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.	Miss Louise O'Dalaigh	Ophthalmology Acute Services Manager	WHSCT
11.	Mrs Margaret McMullan	Optometric Adviser	HSCB
12.	Mr Matthew Dolan	Pharmacy Co-ordinator (Belfast)	HSCB
13.	Mr Raymond Curran	Head of Optometry	HSCB
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

APPENDIX 2

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	Optometry	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.	Dr Patrick Hassett	Ophthalmology	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	HSCB
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	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

APPENDIX 2

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	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

APPENDIX 2

	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 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

Appendix 3: Task Group Terms of Reference

DEP Task Group 1 – Workforce and Legislative Issues

DEP Objectives	Terms of Reference	Measurable Outcomes
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.	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. To coordinate the development and dissemination of an appropriate training and professional development (TPD) plan to underpin any eyecare service reforms proposed by DEP Task Groups. 6. To work to secure the resources necessary for the implementation of the DEP TPD plan.	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 to be used to inform service provision and support the work of other DEP Task Groups. DEP TPD plan, detailing TPD issues/needs and including information on target group(s); target timeframes for delivery; suggested delivery methodologies, including implementation monitoring and evaluation; resource implications; oversight arrangements; accreditation arrangements. Appropriate levels of resourcing to enable implementation of the DEP TPD plan.

DEP Task Group 2 – Integrated Models/Pathways

APPENDIX 3

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 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.	1. To ensure that eyecare service models for long term conditions are in line with DEP, TYC and the wider VISION 2020 agenda. 2. 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. 3. 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.

DEP Task Group 3 – Regional Measurement

APPENDIX 3

DEP Objectives	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.

DEP Task Group 4 – Regional Acute Eye Pathway

DEP Objectives	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.To develop 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. The development of 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. To reduce the number of attendees at Eye Casualty in the RVH by providing services nearer to home. 4. To develop multidisciplinary teams to manage the acute eye in peripheral locations.

DEP 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 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.	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 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 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 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.

APPENDIX 3

Certification of Visual Impairment Subgroup

DEP Objectives	Terms of Reference	Measurable Outcomes
Objective 6b: Pathways for eyecare will ensure that blind/partially sighted certification and registration processes are appropriately conducted.	1. To examine the application of the CVI and Registration processes in Northern Ireland and to make specific recommendations for change or improvement. 2. To engage with DEP Task Group 2 to ensure CVI processes are reflected in care pathways 3. To engage with DEP Task Group 1 to ensure that an effective regulatory framework is in place for certification 4. To consider a broad range of issues affecting certification and registration	Revised CVI process and associated processes, procedures and guidance.

10,000 Voices Working Group

DEP Objectives	Terms of Reference	Measurable Outcomes
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.*	1. To develop a qualitative survey tool using SENSEMAKER Methodology. 2. To establish a baseline assessment of the impact of eyecare service developments. 3. To identify recurring themes from personal experience accounts to assist in the improvement of services.	1. A clear baseline of eyecare service user experience. 2. Increase the profile of service user experience as a key element of service commissioning and improvement. 3. Increase professional awareness of changes required in clinical practice/systems in response to patient/client experience information 4. Incorporate the findings of the audit into eyecare service model improvement plan which results in improved experience of care.

APPENDIX 3

DEP Research Group

DEP Objectives	Terms of Reference	Measurable Outcomes
12a. HSCB/PHA working in collaboration with relevant organisations will lead on the implementation of the eyecare strategy.	To create a research agenda for DEP through discussions of possible key areas of research. To create a matrix taking important factors into consideration including: ➢ Importance ➢ Impact ➢ Relevance to the NHS ➢ Feasibility (Cost / Barriers)	A research agenda put into place in order to implement feasible and important interventions to improve eye health for people of Northern Ireland.

Appendix 4: Southern Primary Eyecare Acute Referral Service (SPEARS) Pilot - Key Findings

The Southern Primary Eyecare Assessment & Referral Service Pilot (SPEARS) pilot commenced on 1st September 2014 to run for one year to 31st August 2015 with 16 optometrists in 12 practices accredited. Additional funding was approved to extend the pilot until 31st March 2016 to enable full evaluation to be carried out without a break in service provision.

From 1st September 2014 to 31st August 2015 **861** patients with acute, sudden onset, eye problems attended an accredited optometrist for a First SPEARS assessment. In addition, **101** follow-up SPEARS assessments were provided to patients who required a follow up. Therefore a total of **962** SPEARS assessments were delivered during the pilot.

Following assessment patients were either managed by the optometrist if their condition was minor and non-sight-threatening e.g. conjunctivitis, minor foreign body, or triaged for onward referral if their condition was more serious and potentially sight-threatening as shown in the table below.

The SPEARS pilot evaluation report[xii] was produced in March 2016. Some of the key findings are outlined below.

Outcome	Management	Number	%
Managed in optometry practice	Discharged with advice following assessment	356	41.3%
	Given treatment	339	39.4%
	Required follow up appointment	101	11.7%
	Full sight test booked	7	0.8%
	Total managed in practice	**695**	**81.5%**
Referred	Secondary care	102	11.8%
	GP	40	4.6%
	Other	14	1.6%
	Total referred on to other healthcare provider	**166**	**18%**

Overall **81.5 %** of patients were managed in primary care optometric practice. Of these 11.7% required a follow-up appointment which is in line with similar services in other parts of the UK.

11.8% of patients were referred to secondary care. The majority of these were referred urgently to BHSCT Eye Casualty with some to the BHSCT Macular service, to the SHSCT Minor injuries Unit for foreign body removal, and one to each of Craigavon Area and Altnagelvin Area Hospitals.

4.6% were referred to their GP; these patients had conditions that were suspected of having a systemic origin e.g. vascular problems or where no ocular diagnoses could be made. 1.6% were referred elsewhere including privately to ophthalmology at the patient's request. Only 3/256 (1.17%) of patients required further, secondary care, intervention following management by the SPEARS accredited optometrist.

A sample of 254 clinical records, (2 were unavailable), was reviewed by a consultant ophthalmologist to assess the '*appropriateness'* of the following elements of service provision and ophthalmic care provision:

- Referral (i.e. Attendance) for SPEARS assessment
- The optometric investigation
- The optometric management and treatment
- Triage for onward referral

The clinical audit and review of clinical records evidenced that presentation for assessment and the subsequent optometric investigation and management were appropriate in the vast majority of cases.

100 patient questionnaires were issued during a three month period from May to July 2015 with a return rate of 56%. Analysis of the questionnaire returns evidence of high patient satisfaction with 51 patients (87%) reporting that they were 'extremely satisfied' with the service. There were no reports of 'dissatisfaction'.

Patients were asked if they would attend their optometrist again if they had a sudden onset eye problem and 54 patients **(96%)** responded that they would**.** In the absence of a SPEARS service:

- 53% advised that they would have attended their optometrist anyway.
- 47% (36 patients) reported that they would have chosen to attend another healthcare provider and the majority of these stated that they would have attended their GP

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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