Community Eyecare Services in Northern Ireland: putting the patient at the centre, improving outcomes and maximising system resource

BY RAYMOND CURRAN

The UK has four healthcare systems; Northern Ireland, Scotland and Wales each has autonomous legislature that develops health policy, while the UK government directly runs England's NHS. Like the other nations, Northern Ireland is continually challenged to meet the needs and demands of the resident population, 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.

The strategic direction towards an integrated and coordinated approach to eye care services is informed by the 2012 publication 'Developing Eyecare Partnerships (DEP): Improving the Commissioning and Provision of Eyecare Services in Northern Ireland' [1]. This supports 'Northern Ireland's Health and Wellbeing 2026: Delivering Together blueprint for health and social care' [2]. DEP is a five year strategy, co-lead by the author (Health and Social Care Board (HSCB)) and a consultant public health colleague from the Public Health Agency (PHA) NI. The 2016 DEP annual report [3] outlines the challenges and successes to date, as well as future plans. Implicit in this is the acknowledgement that co-produced, partnership working is essential to maximise resource and improve outcomes.

Workforce and legislative

Primary eye care in the UK operates under different contractual arrangements. Whilst all aspire to provide safe and accessible primary eye care services, the frameworks to achieve this, and the scope of practice within the core General Ophthalmic Services (GOS) contracts, vary across regions. Recognising that significant contractual change in Northern Ireland would require detailed policy development, drafting and consultation, any reform and transformation developments aimed at primary care service improvements are currently delivered via a Local Enhanced Services (LES) governance structure. As such, the minor eye conditions service in one area of the region is delivered via a LES, as are the regional repeat measures (suspect OHT) and enhanced case-finding for glaucoma / ocular hypertension (OHT) enhanced services.

In terms of workforce, there is no evidence to suggest that the primary eye care workforce is facing the same challenges that currently face primary care GP colleagues. Timely access to GOS does not appear to be a problem, although ensuring marginalised groups access equitably remains a challenge.

In terms of workforce planning across secondary care, however, more research and planning may be required. To meet the needs of the population 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 (MDTs) will impact on the system.

Pathways for long-term conditions and cataract

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 has been to plot pathways, considering National Institute of Health & Care Excellence (NICE) and other relevant guidelines, reducing variation and maximising resource to streamline services and improve clinical and patient-reported outcomes.

Much of the reform and transformation of services delivered by DEP is underpinned by improved interfaces between primary and secondary care. Not least of these is the deployment of secure e-Referral via the NI HSC Clinical Communications Gateway (CCG). This game-changing technology allows primary care optometry to refer directly to secondary care electronically and with ability to append scans, images, field plots and diagnostic aids. This in turn allows the receiving ophthalmologist to e-Triage and, where appropriate, offer referral for advice rather than offer an unnecessary outpatient appointment. As the referring optometrist is also on the Patient Administration System (PAS) master file, it is planned that a notification of any referral outcome is automatically generated to the referrer. As CCG referrals are hosted within the Northern Ireland Electronic Care Record (NIECR) the GP is kept informed but not directly involved in the referral decision-making. This frees capacity in GP primary care.

One further innovative service development being deployed to maximise system resource and "move knowledge not people" is Project ECHO® [4]. This novel and transformational tele mentoring knowledge network has demonstrated an ability to expand capacity in primary care, and offer a framework of governance, communication and learning that will enable some low risk care (in OHT, glaucoma and macular reviews) to be stepped down to a primary care provider. HSC views this as a major enabler for system wide reform in many subspecialties. Eye care services are proud to be at the vanguard of this innovation.

Regional data capture and analysis

There is a wealth of data captured in eye 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.

The advantages of e-Referral are again evidenced by interrogation of this data capture and analysis, as the analytics allow easy reference to referral source, suspected condition and clinic location. Figure 1 demonstrates an analysis of e-Referral activity during the first five months of the phased implementation of e-Referral in optometry practices. Analysis of referral activity allows better planning and will even inform the workforce planning agenda.

Clinically-indicated review dates should be meaningful and, in a system under pressure, there is a general move towards no routine review. For those cases which do require review, this review date should be recorded, reported on, and, with a suite of indicators in place, performance-managed to improve patient safety and outcomes. This is a work in progress.

Acute Eye Pathway

Evidence from one of Northern Ireland's ophthalmology provider Trusts has suggested that as many as 59% attendances at eye casualty could have been safely and appropriately managed in primary care. Consequently, guidance advice for referrers to help with prioritisation and decision-making was produced (Figure 2).

A non-sight-threatening acute eye service was also commissioned in Northern Ireland's Southern Local Commissioning Group (LCG) area [5]. An evaluation and impact report of the pilot service was very positive, with 100% patients able to access the service within 48 hours, 96% clinical agreement against the gold standard, excellent patient outcome and experience measures, and appropriate health economics appraisal. The service is currently funded and available across the entire Southern LCG area. It is hoped that resources will become available to roll this service out regionally, treating and managing more people closer to home and freeing up GP and secondary care capacity.

Ophthalmic Public Health

DEP has been proactive in scoping, planning and delivering work to address the ophthalmic public health agenda in Northern Ireland. A vital and integral constituent of DEP is to ensure that the public are furnished with information to enable them to make informed decisions

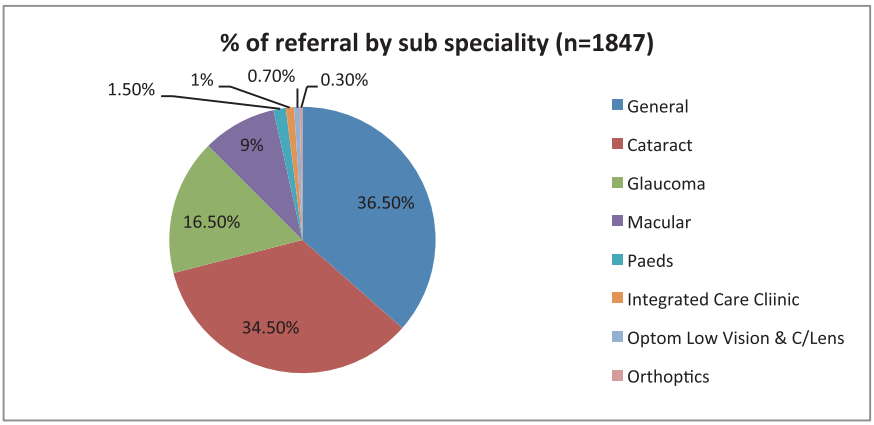

Figure 1: % of referrals by subspeciality (n=1847).

Health and Social Care in Northern Ireland

Produced by Eye Casualty Working Group BHSCT

OPHTHALMOLOGY REFERRAL PATHWAY FOR N. IRELAND

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

Figure 2: DEP: Ophthalmology Referral Advice and Guidance Poster.

about their eye health. The challenges of reaching marginalised and disadvantaged groups is being addressed through initiatives and messages that can be easily embedded into eye care pathways to improve patient outcomes.

Of equal importance is to ensure that those who do have a visual impairment are identified and given the appropriate support to manage their condition and visual impairment. DEP has progressed work to reform and simplify the process for certification of visual impairment (CVI) and to ensure that social care and rehabilitation support are made available to service users at the correct point in time. The HSCB has supported and funded the introduction of Eye Care Liaison Officers (ECLOs) across all main eye clinics in Northern Ireland. ECLOs are a valuable resource within the clinics, providing timely and essential support services for patients who have been diagnosed with an eye condition and for those with long-term conditions who are under review by the hospital eye services.

Core areas of ophthalmic public health work which are being actively addressed are: smoking and eye health, prevention of eye injury, access to eye care for marginalised groups and raising awareness of the link between vison and falls. At a higher level, the group are working to establish ophthalmic public health indicators which will be used as a benchmark to measure outcomes, further informing the future DEP.

Lessons to learn

Developing and improving eye care services is an ongoing process that requires continual modification and re-evaluation. With our ageing population, ever improving treatment regimens and public finance challenges, this is not easy, Northern Ireland is building the intelligence to inform this process, and developing pathways and networks to help future proof care. Replicating such good practice models elsewhere in the UK may be something to be considered by other healthcare managers.

References

1. Developing Eyecare Partnerships: Improving the Commissioning and Provision of Eyecare Services in Northern Ireland, October 2012. Department of Health Social Services and Public Safety (now Department of Health).
2. Health and Wellbeing 2026: Delivering Together, October 2016. Department of Health Northern Ireland.
3. Developing Eyecare Partnerships: Fourth Annual Report (October 2015 – September 2016), Health and Social Care Board.
4. Project ECHO Northern Ireland: Extension for Community Health Outcomes. http://echonorthernireland.co.uk/
5. Southern Primary Eyecare Assessment and Referral Service: Pilot Evaluation Report, March 2016.

AUTHOR

Raymond Curran,

Head of Ophthalmic Services for Northern Ireland's commissioning organisation, Health & Social Care Board.

SECTION EDITOR

Dr Janet E Pooley,

Programme Director, NHS Education for Scotland.

E: janetpooley@nhs.net