

# PRIMARY CARE Eye Services Review Group APPENDICES



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

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## Appendix 1: Copy of Eye Services Survey



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

### Primary Care Eye Services Review 2015 USER FEEDBACK

The HSE Primary Care Division is undertaking a comprehensive review of Primary Eye Care Services to look at the current service in terms of quality, safety and consistency and to identify issues for action. The review process aims to provide a clear blueprint with recommendations for the delivery of primary care eye services which will ensure a high quality, safe and consistent service for patients. A report and recommendations will be published in the summer.

An important part of the review is to talk to patients and service users. Your opinion is important so please take a moment to answer a few questions.

1. Clinic Location _____
2. Adult or Paediatric Patient _____
3. Community or Hospital Clinic _____
What worked well today?
What could have been done better?
What should always be done to lead to a better service?
Other Comments:

THANK YOU

## *Appendix 2: Copy of Memorandum that Issued to Each ISA Manager*

### **MEMORANDUM**

**To:** Each ISA Manager

**From:** Brian Murphy, Head of Planning, Performance & Programme Management, Primary Care Division

**Cc:** Aisling Heffernan, Programme Manager, Primary Care Division  
Shirley Keane, Business Manager, Primary Care Division

**Date:** 9<sup>th</sup> December 2014

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The Primary Care Division convened a Primary Care Eye Services Review Group (PCESRG) in August 2014 to review all primary care eye services.

The following are the terms of reference for the review group:

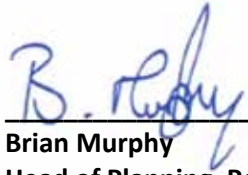
- Examine and document the primary care eye services currently provided to children and adults nationwide including HSE directly provided services and contracted primary care services.
- Determine and document the needs of the population for primary care eye services.
- Review the current primary care eye services in terms of quality, safety and consistency and identify issues for action.
- Set out a clear blueprint with recommendations for the delivery of primary care eye services which will ensure a high quality, safe and consistent service for patients.
  - a. Put in place an action plan to address immediate primary care paediatric eye services issues in the Dublin area.

The group, chaired by me, meets monthly and aims to have a draft report completed by early 2015 with recommendations for implementation throughout 2015-2016.

There will be a consultation process in December 2014 and the following stakeholders have been invited to attend:

- |   |   |
|---|---|
| 1. Association of Optometrists Ireland                | 12. Irish College of Ophthal-mologists      |
| 2. Chief Medical Officer, DoH                         | 13. Irish Guide Dogs for the Blind          |
| 3. ChildVision  | 14. Irish Hospitals Consultants Association |
| 4. CORU   | 15. Irish Medical Council                   |
| 5. Department of Education – Visiting Teacher Service | 16. Irish Medical Organisation              |
| 6. Deputy Chief Nursing Officer, DoH                  | 17. National Coalition for Vision Health    |
| 7. Federation of Opticians Ireland                    | 18. National Council for the Blind Ireland  |
| 8. Fighting Blindness                                 | 19. Nursing & Midwifery Board of Ireland    |
| 9. HSE Office of Nursing and Midwifery Services       | 20. Disability Unit, DoH                    |
| 10. Irish Association of Dispensing Opticians         | 21. The Opticians Board                     |
| 11. Irish College of General Practitioners            | 22. TUSLA – Child & Family Agency           |

Please inform your relevant staff of this review and if they wish to provide feedback can I ask that your office collates this feedback and returns it to Ms Aisling Heffernan, Programme Manager with the Primary Care Division at [aisling.heffernan@hse.ie](mailto:aisling.heffernan@hse.ie) by Friday the 16<sup>th</sup> January 2015.



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**Brian Murphy**  
**Head of Planning, Performance & Programme Management**  
**Primary Care Division**

*Appendix 3: Copy of Memorandum that Issued to the Assistant National Director for Acute Hospitals*

**MEMORANDUM**

**To:** Ms Angela Fitzgerald, A/National Director for Acute Hospitals

**From:** Brian Murphy, Head of Planning, Performance & Programme Management, Primary Care Division

**Cc:** Aisling Heffernan, Programme Manager, Primary Care Division  
Shirley Keane, Business Manager, Primary Care Division

**Date:** 9<sup>th</sup> December 2014

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| 2. Chief Medical Officer, DoH                         | 9. HSE Office of Nursing and Midwifery Services |
| 3. ChildVision  | 10. Irish Association of Dispensing Opticians   |
| 4. CORU   | 11. Irish College of General Practitioners      |
| 5. Department of Education – Visiting Teacher Service | 12. Irish College of Ophthal-mologists          |
| 6. Deputy Chief Nursing Officer, DoH                  | 13. Irish Guide Dogs for the Blind              |
| 7. Federation of Opticians Ireland                    |   |

- 14. Irish Hospitals Consultants Association
- 15. Irish Medical Council
- 16. Irish Medical Organisation
- 17. National Coalition for Vision Health

- 18. National Council for the Blind Ireland
- 19. Nursing & Midwifery Board of Ireland
- 20. Disability Unit, DoH
- 21. The Opticians Board
- 22. TUSLA – Child & Family Agency

Can you arrange to have this correspondence issued to all appropriate acute services personnel including management in the Hospital Groups to enable them to make submissions to the review process. Can you also assign a designated person within the Acute Division to collate responses from the acute sector and forward them directly to Aisling Heffernan, Programme Manager, Primary Care Eye Services Review Group at [aisling.heffernan@hse.ie](mailto:aisling.heffernan@hse.ie) The Submissions should be forwarded to Aisling by 15<sup>th</sup> January 2015.



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**Brian Murphy**  
**Head of Planning, Performance & Programme Management**  
**Primary Care Division**



#### *Appendix 4: Summary & Full Submission from the Association of Optometrists Ireland (AOI)*

##### *Summary Submission from the Association of Optometrists Ireland (AOI)*

The profession of optometry comprises an integral but under-utilised primary eye care service in Ireland. The current public health contributions of optometrists include (a) the provision of eye examinations and optical appliances where required to approximately 300,000 adult medical card patients annually, (b) the referral of the vast majority of patients requiring secondary and tertiary care for acute and chronic eye disease, and (c) provision of paediatric eye examinations in some instances for children having failed school screening. In addition, a number of recent pilot schemes have also served to integrate optometrists in the care pathways of patients undergoing treatment for ocular disease including cataract and glaucoma. The scope of practice and skills of optometrists, however, far exceed the level supported under current contractual arrangements for medical card holders (for example, optometrists can provide an enhanced primary care role including elements such as preventive health, health education, promotion and maintenance, detection, diagnosis, management and referral of disease among others).

Blindness and visual impairment represent a significant burden to society, in that the cost in terms of loss of quality of life, lost productivity, rehabilitation and education are high and increasing. Current waiting lists for eye care are undesirable, and the situation is deteriorating. Without systematic reform of current care pathways for detection, treatment, prevention and long-term care of serious eye disease, visual impairment and blindness prevalence will continue to grow unabated and to exert an unsustainable human and financial cost. The swift and effective use of all available resources to promote eye health and prevent debilitating sight loss can, however, reduce future healthcare dependency.

In addition to the wealth of evidence available from the UK, two recent joint optometry/ophthalmology pilot co-management schemes provide critical evidence as to the capacity of optometrists to facilitate a transfer of care to community settings and thereby release hospital appointments and enhance patient experience in a manner that is safe and cost effective. Recently conducted optometrist surveys also provide useful evidence as to the interest and capacity of optometry as a profession in Ireland to engage in an enhanced care model.

This submission proposes a fully integrated role for optometry, deeply embedded as the primary eye care provider funded to provide an enhanced level of primary care service, but also with a presence in the secondary (which includes COSS/COSMTS contracted providers and multidisciplinary COP led teams) and tertiary care sectors as outlined in Figure 5.3. Further, optometrists would take a formal role in evolved primary care management structures.

Primary Care Role	Secondary Care Role	Tertiary Care Role
Primary eye care leader. Services provided in conjunction with GPs. Management role on Primary Care Network Management Teams.	Optometrists integrated in multidisciplinary community teams comprising GPs, orthoptists, PHNs and other relevant professionals with ophthalmologist clinical leads.	Hospital optometrists appointed to provide specialist services including low vision, paediatrics, and shared care to release hospital ophthalmology resources.

##### *Central Primary Care Optometry Role, but integrated also in Secondary and Tertiary Care (AOI)*

Although the integration of optometry into multidisciplinary community and hospital teams is an important step, the expansion of the funded primary care role of optometrists in Ireland beyond the provision of basic eye examinations and spectacles is perhaps even more important, whereby the optometry profession can deliver annual cost benefits equivalent to the £440 million now being realised annually in Scotland.

Community optometry can take a lead role at the forefront of primary eye care, to deliver high quality, patient centred and cost effective healthcare in accessible community settings. Within the core competencies of existing training, or with additional hospital based training, optometrists can deliver on Government objectives for more care, better outcomes, improved accessibility and better quality within increasingly restricted resources. It is anticipated that an expanded primary care optometry service delivery role, combined with integration into multidisciplinary secondary care community teams, and appointment to hospital teams will reduce the ophthalmic care burden on overloaded HSE resources, with key benefits including:

- Increased capacity in eye care services for acute service delivery;
- Significantly shorter waiting lists;
- Enhanced community based eye care service provision;
- More efficient and cost-effective use of secondary care resources.
- Improved cost efficiency and lower examination unit-costs
- Improved accessibility, experience and outcomes for patients in community care

# PRIMARY CARE EYE SERVICES REVIEW GROUP CONSULTATION

PRIMARY CARE OPTOMETRY STRATEGY



Association of  
Optometrists Ireland

ASSOCIATION OF OPTOMETRISTS IRELAND  
DECEMBER 2014

## Executive Summary

Two principle objectives are core to the primary eye care strategy outlined herein: to ensure that system and policy reform delivers a primary eye care service that is available and accessible to all sectors of Irish society, in particular to redress current inequities that affect vulnerable groups including children, the elderly and those at risk of blindness; to eliminate all cases of avoidable blindness and visual impairment through a comprehensive package of preventive and promotive measures. These objectives can only be realised through an integrated care approach that optimises the use of all skilled resources to deliver more accessible, more cost effective, patient centred and high quality hospital, community and continuing care.

Blindness and visual impairment represent a significant burden to society, in that the cost in terms of loss of quality of life, lost productivity, rehabilitation and education are high and increasing. Current waiting lists for eye care are undesirable, and the situation is deteriorating. Without systematic reform of current care pathways for detection, treatment, prevention and long-term care of serious eye disease, visual impairment and blindness prevalence will continue to grow unabated and to exert an unsustainable human and financial cost. The swift and effective use of all available resources to promote eye health and prevent debilitating sight loss can, however, reduce future healthcare dependency.

Community optometry can take a lead role at the forefront of primary eye care, to deliver high quality, safe and cost effective healthcare in accessible community settings. Within the core competencies of existing training, or with minimal upskilling, optometrists can deliver on Government objectives for more care, better outcomes, improved accessibility and better quality within increasingly restricted resources. It is anticipated that an expanded primary care optometry service delivery role, combined with integration into multidisciplinary secondary care community teams, and appointment to hospital teams will reduce the eye care burden on overloaded HSE resources. Key benefits will include:

- increased capacity in eye care services for acute service delivery;
- significantly shorter waiting lists (e.g. paediatrics up to 5 years);
- enhanced community based eye care service provision;
- more efficient and cost-effective use of secondary care resources.
- improved cost efficiency and lower examination unit-costs
- improved accessibility, experience and outcomes for patients in community care

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Appendix 4 –	Core competencies for final year students of optometry
Appendix 5 -	CPD Approval Request Form
Appendix 6 -	North West Cataract Scheme Competency Framework

"Optometrists have the skills and resources to provide enhanced and patient-centred eye care. With lifelong ocular disease prevalence such as AMD, diabetes and glaucoma set to double by 2050, there is an urgent need for primary eye care evolution to meet the ever-increasing demand for eye care services. Optometrists can make an immediate and sustained impact, deliver shorter waiting lists, shorter waiting times and easily accessible services through community-based and cost-effective primary eye care provision."

## Statement of Primary Care Issues

An effective national primary eye care service should be an integrated, community based model of care. This service should aim to reduce the incidence of preventable blindness and vision impairment through early detection and treatment/management of disease, while also providing quality of life enhancement, and health gain/promotion. This should be provided as close to the patient's home as possible, in a timely manner, and with equity of service provision throughout the country. This service should include provision for review and audit of costs, waiting times, numbers of examinations, treatments provided and patient satisfaction.

In our view the current model of service fails to deliver this for the following reasons:

- The statutory necessity for Optometry to refer has lengthened waiting lists and times unnecessarily.
- The skills mix employed within the public service does not represent the best use of resources and has meant considerable underutilisation of the skill sets available in Optometry and Ophthalmology, with the result that an excessive burden is being placed on secondary and tertiary care.
- Poorly resourced and equipped secondary care clinics have also contributed considerably to the pressure on the hospital/tertiary system.
- Communication and information flow between the professions has been inadequate.
- Restrictions by the health regulations on access to community clinics by direct referral from Optometrists places an unnecessary burden on the hospital OPD/ A & E departments, while policies at some hospitals to charge for direct referrals from Optometry to Emergency Departments puts an additional burden on the patient or creates an unnecessary GP visit – [see Appendix 1](#) [Health (Out-Patient Charges) Regulations 2013 – Statutory Instrument 45].
- There is considerable inequity nationally in service provision under the Community Ophthalmic Services Scheme (COSS) depending on location. Unlike the Optical Benefit Scheme operated by the Department of Social Protection, COSS authorisations are not centralised, instead they are issued by about 30 local HSE offices and as a result there are many variations and inequities around the country. Evidence of the disparities in local policies for paediatric care is provided through an Association of Optometrists Ireland (AOI) practitioner survey – [see Appendix 2](#).
- There is inadequate and inequitable local access to service, and patients often have to travel considerable distances which can be particularly problematic in cases of visual loss/disturbance.
- There are no national statistics or effective cost analyses available to measure service efficacy.
- Existing paediatric screening services are ineffective, often add considerably and unnecessarily to waiting lists and are a very poor use of manpower and resource - [see Appendix 2](#).
- Post-primary school children who are not medical card holders are excluded from the public system, and in some counties, even patients with medical cards are excluded from using community optometry services.
- There is poor integration between the services provided and inadequate referral protocols. Variations in referral pathways also create inequity in terms of access to care. In a recent Health Information and Quality Authority (HIQA) report, it was noted that there is regional variation in cataract referral pathways for example,

particularly in relation to the ability of community-based ophthalmologists (operating through the COP, COSS and COSMTS schemes) to list patient directly for surgery without the need for further review by a hospital-based ophthalmologist. It was suggested that the additional steps in some regions could add 12-24 months to the overall patient journey.<sup>1</sup> – see Appendix 3

- The Community Ophthalmic Medical Treatment Scheme (COSMTS) is potentially a very useful scheme if applied appropriately and as intended for the cost effective medical treatment of ocular abnormalities within community settings. The scheme as it is currently operated, however, crosses the primary-secondary care divide. The variation in patient referral patterns to hospital outpatient clinics compared to COSMTS providers illustrates this point clearly. Approximately 90% of hospital referrals are from optometrists. An audit of the source of referrals received by seven community ophthalmic practices found that the sources of referrals to these practices for secondary eye care were; GPs 33%, Optometrists 20% and others (including self referral) 47%.<sup>2</sup> The apparently high percentage of self-referrals is particularly important, and likely represents an inappropriate use of this potentially valuable resource. While the COSMTS scheme might deliver cost effective treatment in comparison to tertiary care options, the cost of providing a primary care service to patients electing to attend an ophthalmologist rather than an optometrist in the community represents a poor use of resources at substantially increased cost to the exchequer. A HSE audit of the COSMTS scheme to determine its overall value for money would, therefore, seem prudent.

### Primary Eye Care Definition

Primary Care A New Direction defines primary care as “An approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services”.<sup>3</sup>

Primary eye care is an integral part of comprehensive eye care. It is targeted not only towards preventing blindness and visual impairment, but also towards providing services to redress ocular morbidity. Primary eye care is a frontline activity, providing care and identifying disease before it becomes a serious medical condition. Primary eye care is delivered in many different ways. However, it all aims at making eye care services available within reach of the community. In the long run this allows for better penetration of services and reduced downstream direct and indirect costs of blindness and visual impairment.

Even a cursory review of systems across the world reveals that there is no common understanding of what primary eye care means, and there exists a wide variation both in its content and in the way in which it is delivered. The principles of primary health care (i.e., fair distribution; community involvement; focus on prevention; appropriate technology; multi-sectoral approach) should, however, all apply in primary eye care.

### Factors Promoting Evolution in Primary Care Service Delivery

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<sup>1</sup> Health Technology Assessment of Scheduled Surgical Procedures: Cataract Surgery. Health Information and Quality Authority, April 2013

<sup>2</sup> Audit of Referrals to Community Ophthalmic Practices. Irish College of Ophthalmologists, Nov 2013.

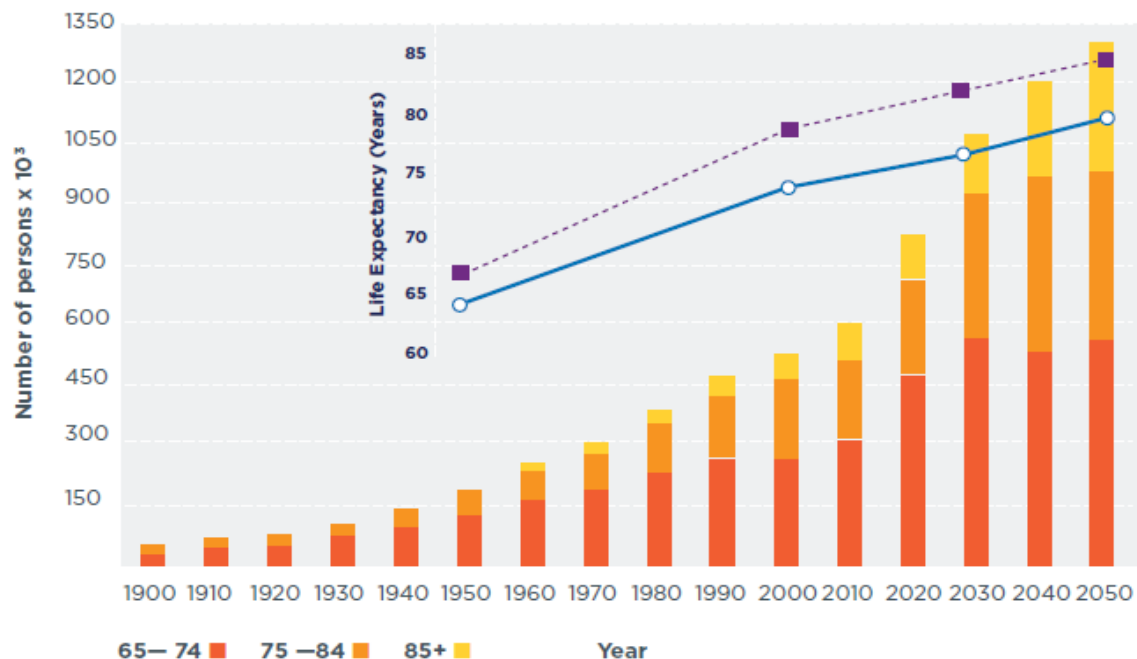
<sup>3</sup> Primary Care, A New Direction, 2001



Changing demographics in Ireland are causing a steady increase in demand for eyecare services.<sup>4</sup> The Economic and Social Research Institute (ESRI) published a report in 2009 projecting an overall population change from 4.24 million in 2006 to 5.1 million in 2021.<sup>1</sup> More notably, life expectancy is increasing (see Figure 1), and significant population ageing is predicted, with an absolute increase of 42,900 individuals over the age of 65 by 2021. According to 2011 Census data as reported in the National Service Plan 2014 (HSE, 2014),<sup>5</sup> these projections continue to manifest:

The population has grown by 8% since 2006.

The number of people over 65 years of age increased by 14% since 2006.



**Figure 1: Life expectancy trends and predictions to 2050, and changing proportions of persons aged 65 and over**

As older persons are disproportionately heavy users of healthcare services, this has implications for resource funding and management. With increased longevity comes an increase in the prevalence of age-related morbidities, including irreversible eye disease, that have a deleterious effect on health-related quality of life, including the most common causes of blindness such as age-related macular degeneration (AMD), diabetic retinopathy (DR) and glaucoma.<sup>6</sup> Eye care services as currently provided in Ireland are at capacity. Waiting lists for eye care are unacceptable, in excess of two years or closed in some centres. This has direct prognostic implications, and consequences for blindness prevalence in Ireland. Estimates suggest that there were 224,832 people suffering from visual impairment in 2010, which has been projected to rise to 271,996 by 2020 - a 21% increase.<sup>7</sup> Population growth and increasing life expectancy will further escalate this pattern of increasing visual impairment. The total economic cost of visual impairment and blindness in the Republic of Ireland

<sup>4</sup> Layte, R et al. Projecting the Impact of Demographic Change on the Demand for and Delivery of Health Care in Ireland. Dublin: Economic and Social Research Institute. 2009.

<sup>5</sup> Health Services Executive. Health Service National Service Plan 2014 Our Service Priorities. 2014

<sup>6</sup> Kelliher C, Kenny D, O'Brien C. Trends in blind registration in the adult population of the Republic of Ireland 1996-2003. Br J Ophthalmol 2006; 90(3): 367-71.

<sup>7</sup> Deloitte Access Economics. The Economic Impact of Vision Impairment and Blindness in the Republic of Ireland. Dublin: NCBI (National Council for the Blind of Ireland). 2011.

was estimated at €2.14 billion in 2010, but is projected to rise to €2.7 billion by 2020.<sup>4</sup> From economic and societal perspectives, this increased level of avoidable visual impairment is unacceptable and contrary to the St Vincent's Declaration (1989), and World Health Organization's Vision 2020: Right to Sight. Early detection and effective management can delay disease progression, prevent debilitating sight loss, minimise future dependency on health care services and attenuate consequential productivity losses.<sup>8</sup> With a larger population at risk of developing these sight-threatening conditions, systematic reform of current policy and practice for the detection, treatment, prevention and long-term care of serious eye disease is imperative.

### *Role of optometrists in primary enhanced eye care services*

In the UK, the last decade has seen a strategic reformation of the role of optometrists in primary care settings. Their role has expanded to include an ever-increasing involvement in specialist eyecare. This shift has been facilitated by legislative changes that have removed barriers to an extended role in the primary care setting. In 2007, The Department of Health in the UK published the 'Commissioning Toolkit for Community Based Eye Care Services', which serves as a guide to increase optometrist involvement in primary eye care pathways.<sup>9</sup> It describes 'enhanced eye care', in which optometrists are empowered to provide enhanced services, co-manage chronic eye problems and be part of direct referral pathways, allowing patients to be seen and treated in a more timely manner than standard referral pathways.<sup>6</sup> The UK has thereby transitioned, in many places, to a model in which the optometrist is fully integrated as the primary eye care practitioner, serving to triage primary care patients, manage where appropriate, and refer to secondary or tertiary care only when necessary.<sup>10,11</sup>

In response to a recent White Paper 'Equity and Excellence liberating the NHS',<sup>12</sup> it has been suggested that more patients should be transferred from hospital services to these enhanced community services. Community-based enhanced eyecare services are seen to be more accessible, patient-centred, and offer "more cost-effective care than is possible in some NHS environments".<sup>13</sup>

It appears that patients want more accessible, community-based healthcare services.<sup>14</sup> Evidence also suggests that where community eyecare services are in operation, patient satisfaction remains high.<sup>15,16,17</sup> There is also substantial evidence to provide positive confirmation of the clinical and cost effectiveness of such schemes.<sup>18,19,20,21</sup>

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<sup>8</sup> Traverso C, Walt JG, Kelly SP, et al. Direct costs of glaucoma and severity of the disease: a multinational long term study of resource utilisation in Europe. *Br J Ophthalmol* 2005;89:1\_45-9

<sup>9</sup> Commissioning toolkit for community based eye care services, D.o.Health, Editor.2007.

<sup>10</sup> Association of Optometrists. The Economic Impact of Free Eye Examinations in Scotland'. 4-Consulting, May 2012

<sup>11</sup> Sheen NJL, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM. Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series. *Br J Ophthalmol* 2009;93:435-8

<sup>12</sup> D.o. Health, Equity and excellence: Liberating the NHS, Editor. 2010.

<sup>13</sup> Bosanquet N, Liberating the NHS: Eye Care. Making a reality of equity and excellence. 2010 December, Imperial College London.

<sup>14</sup> Leatherman S, Sutherland K, Patient and Public Experience in the NHS- a Quality Chartbook, in Quest and Quality and Improved Performance. August 2007, The Health Foundation.

<sup>15</sup> Gray SF, Spencer IC, Spry PG, Brookes ST, et al.: The Bristol shared care glaucoma study - "validity of measurements and patient satisfaction. *Journal of Public Health* 1997;19:431-436.

<sup>16</sup> Patel P, GP Ophthalmic Referral Scheme Patient Questionnaire Analysis, C.a.N.W.L.P.P.E. Committee, Editor. 2006.

<sup>17</sup> McLeod H, Dickinson H, Williams I, Robinson S, et al., Evaluation of the chronic eye care services programme: final report, N.E. Pathways, Editor. 2006.

<sup>18</sup> Henson DB, Spencer AF, Harper R and Cadman EJ, Community refinement of glaucoma referrals, *Eye* 2003;17:21-26

<sup>19</sup> Gray SF, Spry PGD, Brookes ST, Peters TJ, Spencer IC, Baker IA, Sparrow JM, Easty DL, The Bristol shared care glaucoma study: outcome at follow up at 2 years, *Br J Ophthalmol* 2000;84:456-463

### Context in Ireland

The expansion of primary care optometry advocated herein represents an “integrated health system” approach, as promoted in the Transformation Programme published by the Health Service Executive (HSE).<sup>22</sup> Expanding the clinical role of community-based optometrists, in partnership with secondary and tertiary referral institutions has the capacity to redirect health services from acute hospitals to community care. This will enable the delivery of more efficient, more patient friendly and high quality care at less cost.

Much of the current workload in ophthalmology inappropriately consists of routine check-ups and monitoring of stable conditions that need lifelong care. Optometric clinical expertise can be utilised to perform routine monitoring and redirect the stable clinical workload out of a hospital environment and into community-based clinics. Optometrists are highly skilled and educated healthcare professionals who are well equipped to carry out the clinical examinations necessary for such routine checks in a safe, competent and standardised way that will enable more efficient use of valuable hospital care resources.

The Report of the Expert Group on Resource Allocation and Financing in the Health Sector (2010)<sup>23</sup> asserts that cost-effective management of chronic diseases should promote the use of multi-disciplinary teams to deliver care, much of which should be community-based, in line with the current primary care strategy. Safe and cost-effective care is recognised as a key goal for the hospital system, but the under-utilisation of resources in the community means that length-of-stay in hospital is often longer than it should be. There continues to be over-reliance on hospital services, and inefficient resource allocation leads to poor value for money for the total health envelope. Disease prevention is also recognised as an effective tool to promote health and well-being, and the report recognises that there is scant reward for health promotion activities, such as could conceivably be delivered by primary eye care community based optometrists, that achieve this.<sup>18</sup>

The Group strongly supports the integration of the Acute Hospital and Primary, Continuing and Community Care pillars and recommends that *“The resource allocation model should promote the integration of care within and across the hospital, primary and community/continuing care sectors at local level”*.<sup>18</sup> Resources must, therefore, support integrated care so that users can get the best combination of health care on clearly defined pathways.

### Framework for Change

In November 2012 a framework for change was published by government entitled *Future Health – A Strategic Framework for Reform of the Health Service 2012-2015*.<sup>24</sup> This framework promises service reform that moves away from the current hospital-centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity that is safe, timely, efficient, and as close to home as possible.<sup>19</sup> Under

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<sup>20</sup> Bourne RR, French KA, Chang L, Borman AD, Hingorani M, Newsom WD. Can a community optometrists based referral scheme reduce false-positive glaucoma hospital referrals without compromising quality of care? The community and hospital allied network glaucoma evaluation scheme (CHANGES). *Eye* 2010; 24(5): 881–887.

<sup>21</sup> Syam P, Rughani K, Vardy SJ, Rimmer T, Fitt A, Husain T, McInerney L, Broome D, Driver R, Wormald R and Ramirez-Florez S: The Peterborough scheme for community specialist optometrists in glaucoma: a feasibility study. *Eye* 2010;1–9

<sup>22</sup> Health Service Executive. Transformation Programme 2007-2010. Dublin: HSE 2007

<sup>23</sup> Report of the Expert Group on Resource Allocation and Financing in the Health Sector. 2010

<sup>24</sup> Health, Dept of. *Future Health A Strategic Framework for Reform of the Health Service 2012 – 2015* Department of Health November 2012.

this framework, the HSE has established 33 national clinical programmes, including eye care, based on three main objectives; to improve the quality of care delivered to all users of HSE services, to improve access to all services and to improve cost effectiveness.

The primary aim of our primary eye care programme is to reduce the number of annual cases of preventable blindness and vision impairment. This can be achieved by developing care pathway guidelines and referral protocols for the treatment of some common eye conditions, and implementing a decentralised community based care model, with clear pathways of referral into secondary care, to acute hospital services and back to the community where clinically appropriate. Optometrists are well placed to provide community based care, with an established base of well-equipped practices (see Table 3) scattered across every region of the country, urban and rural (see Figure 2), and a highly skilled workforce with under-utilised clinical skills and equipment.

The National Coalition for Vision Health in Ireland (NCVHI), a coalition of eye care stakeholders including eye care professionals and service users, outlined the need for reform within the eye care pathway in their 2012 position paper, and acknowledged the establishment of the HSE National Programme for Eye Care as a welcome development. The Coalition proposed that any strategy implemented by the HSE eye care programme would seek to identify opportunities to optimise the role and remit of various health and social care professionals (including Optometrists, Ophthalmic Nurse Specialists, Opticians and Orthoptists) capable of supporting eye health service provision for the ultimate benefit of people with sight loss in Ireland. It was also recommended that resource allocation and service design be guided by evidence-based approaches, and research should serve as a key enabler in the commitment to improve outcomes and the quality of care provided.

The current Minister for Health has acknowledged the need for more integrated workforce planning in eye care and stated that ‘the health workforce needs to be developed and refocused to deliver a greater proportion of care in the community. This will require the development of multidisciplinary teams which, in association with the ophthalmologists, include, for example, specially trained nurses, optometrists, orthoptists and ophthalmic technicians.’

With government, patient advocacy groups and services providers all calling for reform, the political environment is ripe for change. Current capacity in secondary care is not, and will not be, sufficient to meet growing demand. Even on best predictions, over the next twenty years the ophthalmology workforce is going to remain limited, whilst at the same time taking on ever-increasing possibilities for treatment, plus the burdens of medical and other training. Taking full advantage of the skills of optometrists to manage some low-risk patients in a community setting seems a logical step in care pathway reform.

#### Optometry in Ireland

##### Definition of Optometrist;

The profession of Optometry as defined by the World Health Organisation is;  
*A healthcare profession that is autonomous, educated and regulated (licensed/registered), and optometrists are the primary healthcare practitioners of the eye and visual system who provide comprehensive eye and vision care, which includes refraction and dispensing, detection and diagnosis and management of disease in the eye and the rehabilitation of conditions of the visual system”.*

### Education and Training

An Optometrist qualifying in Ireland must complete a four year Bachelor of Science degree in Optometry at Dublin Institute of Technology (DIT), the only provider of optometric education in the Republic of Ireland. In order to practise optometry in Ireland, graduates are required to sit the AOI Professional Qualifying Exams, which are designed to ensure competency to practise. The defined list of core competencies, which has been benchmarked against the UK and international WCO standards, that must be demonstrated by optometrists during their training are listed in [Appendix 4](#). Eligibility to register with the Opticians Board is determined by the outcome of these exams. The level of training delivered at DIT is such that Irish optometrists are legally recognised in Northern Ireland and throughout the UK, to have the required qualifications to meet the enhanced scope of practice requirements in the UK. Numerous postgraduate programmes are available to optometrists in Ireland and overseas, including up to PhD level. The optometry programme has an annual intake of 25 students (CAO entry points in 2014 were 505, ranging from 505 to 560 among students accepted, ranking optometry students in the top 10% of academic achievement nationally). Retention rates are high, such that close to 25 students graduate annually. Many graduates emigrate and employ their skills within community and hospital enhanced care schemes in the UK where Irish optometrists are directly registerable. This represents an avoidable skills loss and waste of exchequer resources.

### Continuous Professional Development (CPD)

The AOI has had its own mandatory CPD compliance scheme since 2008. This was introduced to ensure that Irish Optometrists clinical skills develop and are maintained in line with the required competency to practise, and the growth and development of the profession nationally and internationally. It is a two-year rolling scheme which is measured at 31<sup>st</sup> December every year. At that date each practising member is required to have achieved their CPD target over the preceding two year cycle. The target for each cycle is 30 CPD points, of which 14 must be gained from attendance at “contact type” events, i.e. not distance learning. Members submit their points to the AOI office during the cycle and if they are approved they are logged to their account in the database. Points can be attained from a very wide variety of events and locations, not only Ireland. By way of example, a one-hour contact event attracts 1 CPD point. There is a CPD Approval Committee to assess CPD applications. A CPD Certificate is issued each year to compliant members.

There have been 4 completed cycles to date – 2010, 2011, 2012 & 2013. In the 2012-2013 cycle, for example, 923 individual CPD events were logged, including 440 contact events. In 2012, the total number of points logged was 12,230 (76% from contact events), while in 2013, 13,708 CPD points were logged (79% from contact events). The average number of CPD points achieved per member is 41.5, significantly above the 30 point target. Since inception, only 4 members have been designated non-compliant and therefore not offered renewal of membership.

The range of events is extremely wide but all events are measured against optometrists’ core competencies. They must have relevance to at least one of these. See attached CPD Approval Request Form which is required for events which are not already UK approved – [Appendix 5](#).

### Optometry Community Base

The commissioning of primary eye care services in the community should be based upon the principles of equity of patient access, optimisation of patient outcomes, patient experience and value for money. There are more than 600 highly skilled optometrists practicing in

Ireland, equipped with a comprehensive range of traditional and cutting edge diagnostic equipment, and serving a broad base of urban and rural communities. Optometrists are the most numerous and accessible eye care profession, and are best placed to deliver on the need and desire for community centred eye care delivery without a need for substantial additional training. The distribution of optometrists and ratio to population in each province are presented in Figure 2.

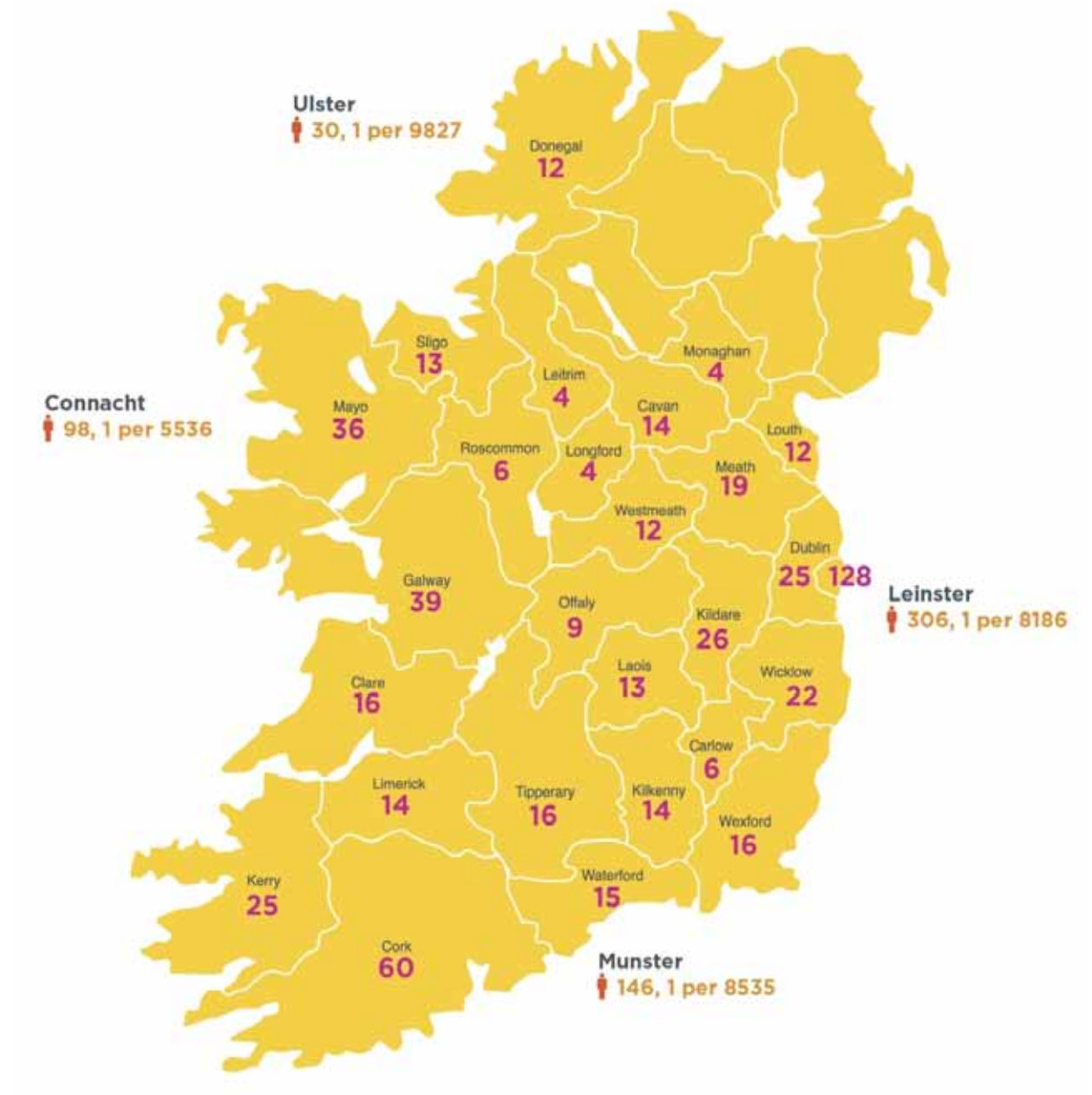
This submission proposes a fully integrated role for optometry, deeply embedded as the primary eye care provider, but also with a presence in the secondary (which includes COSS/COSMTS contracted providers and multidisciplinary COP led teams) and tertiary care sectors as outlined in Table 1. Further, optometrists would take a formal role in evolved primary care management structures.

Primary Care Role	Secondary Care Role	Tertiary Care Role
Primary eye care leader, services provided in conjunction with GPs	Optometrists integrated in multidisciplinary community teams comprising GPs, orthoptists, PHNs and other relevant professionals led by community ophthalmologists	Hospital optometrists appointed to provide specialist services including low vision, paediatrics and shared care to release hospital ophthalmology resources
Management role on Primary Care Network Management Teams		

**Table 1: Central primary care optometry role, but integrated also in secondary and tertiary care**



**Number of AOI member optometrists practising according to geographic location in the Republic of Ireland**



**Overall Total**

580 AOI Optometrists = 1 for every 7403 persons nationwide

*Figure 2: Accessibility of eye health services can be optimised through utilisation of the broad urban and rural base of community optometrists*

**Primary Care Role of Optometrists**

The optometrist has the ability to provide services in the following areas of primary care:

- disease/vision loss prevention

- health education
- health promotion
- health maintenance
- detection, diagnosis and referral of ocular and systemic disease and dysfunction
- treatment and rehabilitation
- counselling referral and information provision
- consultation

Optometry in Ireland currently operates in the private sector, though most practices have contracts to deliver eye care under the PRSI and Medical Card schemes. An optometrist is paid €22.51 by both these schemes to carry out an eye examination. In 2013, optometrists provided 91.23% of all adult examinations conducted within these schemes (see Table 2). The remaining examinations by optometrists are provided to private fee paying patients, including children, who have no entitlement to optometric services under state schemes, but are forced to enter private care due to lengthy waiting lists within the public system.

Medical Card Examinations	PRSI Examinations
287,645	137,330

**Table 2: Number of PRSI and medical card eye examinations conducted by optometrists in 2013**

The capacity of optometrists in Ireland to fulfill a comprehensive primary care role is greatly facilitated by the removal of the prohibition on treatment/management of eye conditions by optometrists under CORU legislation. Scope of practice will no longer be limited by statute, rather by the education, training (including CPD) and experience of individual practitioners. The AOI promote the concept that optometry should be regarded as the lead primary eyecare profession in Ireland, as is the case in Scotland, where every individual is entitled to a community based comprehensive eye examination performed by an optometrist with the required expertise and equipment to meet their individual eye care needs or refer as and when appropriate. By extending the funded primary care role of optometrists in Ireland beyond the provision of basic eye examinations and glasses, the optometry profession can deliver annual cost benefits equivalent to the £440 million now being realised annually in Scotland.<sup>10</sup>

#### Enhanced Primary Eye Care - Research Evidence

It is critical to the successful advancement of primary eye care pathways in Ireland that the strategic decisions regarding the design and implementation of such pathways are evidence based, and that pathway design prioritises effective monitoring and evaluation as a means to determine efficacy and impact of the revised pathways. In this way, pathways can continue to evolve as needs change, and service delivery optimised routinely. There is useful evidence from within the Irish and UK eye health systems that can inform the pathway development process.

#### Ireland Evidence

Two recent joint optometry/ophthalmology pilot co-management schemes provide critical evidence as to the capacity of optometrists to facilitate a transfer of care to community settings and thereby release hospital appointments and enhance patient experience in a manner that is safe and economically attractive. Recently conducted Optometrist surveys also provide useful evidence as to the interest and capacity of optometry as a profession in Ireland to engage in an enhanced care model.



### *National Optometry Centre Glaucoma Referral Refinement (GRR) Scheme*

A GRR scheme was launched in 2012 (directed by Prof. James Loughman and Prof Colm O' Brien, and conducted by Ms. Catriona Barrett) as a research study designed to evaluate the impact of GRR on hospital out-patient referrals from optometry (optometry referrals comprise over 90% of all referrals to ophthalmology). The glaucoma referral refinement exam was designed to align with current practice in the local ophthalmology department. The refinement scheme optometrist underwent a period of training within the hospital ophthalmology department, and established the scheme at the National Optometry Centre, a community based optometry clinic. The scheme was designed based on a model successfully implemented in Manchester in the UK, which succeeded in reducing the number of suspect cases being referred to the Manchester Royal Eye Hospital by 40%, at a cost saving of £17 per patient to the exchequer.<sup>25</sup> The refinement scheme optometrist made a tentative management decision after carrying out the exam. A virtual clinic was used to facilitate masked ophthalmologist case review, after which a final management decision was agreed. 223 patients were recruited into the scheme following referrals from 59 community optometrists in the Greater Dublin Area.

### *Results*

Absolute decision agreement between optometrist and ophthalmologist was 77%. A Cohen's Kappa value of 0.61 was achieved, indicating high inter-observer agreement. Patients seen within the GRR scheme were managed in three ways (1.8% referred with co-morbidity):

	Optometrist Decision	Virtual Clinic Decision	Follow-Up Clinic*
Discharge back to community optometrist	28.6%	29.4%	38%
Monitor in optometrist led GRR clinic	47.4%	40.4%	30%
Refer to secondary care ophthalmology	24%	28.4%	32%

\* Follow up clinic visit conducted 6 months subsequent to initial visit; joint virtual clinic decision outcome presented

**Table 3: Management pathways for patients examined under the GRR scheme**

Of the 223 patients referred into the scheme, only 28% were transferred in total to ophthalmology after initial consultation, and 32% in total including follow-up review, thus releasing the hospital clinic slots that would previously have been assigned to examine over two-thirds of those patients referred, and thereby effectively transferring care back to the community for the majority of patients. This was achieved on the basis of enhanced communication between optometry and ophthalmology, specialist training and the application of a comprehensive examination protocol using appropriate diagnostic equipment. The false positive referral rate compares favourably with UK statistics (40% average). The observed decision agreement rate reinforces the importance of the virtual clinic to facilitate a joint (optometry and ophthalmology) approach to patient management decisions, and serves to optimise patient safety within the scheme.

### *North-West of Ireland Post-Cataract Scheme*

This scheme was developed jointly in 2012 by Sligo General Hospital (led by Paul Mullaney) and the Association of Optometrists Ireland (led by Lynda McGivney-Nolan) in response to

<sup>25</sup> Henson, DB, Spencer AF, Harper R, Cadman E J. (2003). Community refinement of glaucoma referrals. *Eye (London, England)*, 17(1), 21–6. doi:10.1038/sj.eye.6700261

the growing waiting lists in the hospital for cataract surgery in this predominantly rural catchment area. Each practice was required to meet a set of protocols for equipment and training in order to be listed as participants on the scheme - see [Appendix 6](#). Optometrists attended an information session outlining the patient pathway, completion of the Medisoft electronic patient record (EPR), identification of postoperative complications and procedures for re-referring patients with postoperative complications as well as patients requesting second eye cataract surgery. A total of 39 optometric practices took part in this pilot co-management scheme which commenced in August 2013 (there are currently 58 optometrists participating across the North-West). Patients undergoing uncomplicated surgery with no significant ocular co-morbidity were eligible for same day discharge to community optometrists.

### *Results*

At initial evaluation, 1422 patient had been seen and €180,000 savings delivered. As a direct consequence, 1422 extra out-patient clinic slots were made available for other patients, thus positively impacting cataract waiting lists, and avoiding the necessity to outsource surgical treatment.<sup>26</sup> Optometrists were found to provide excellent postoperative care service with superior postoperative feedback rates (i.e. data on refraction, visual acuity, intraocular pressure and cup disc ratio) compared to hospital doctors (optometrists were 5 times more likely to have complete clinical records compared to hospital doctors) and similar rates of re-referring for second eye surgery.<sup>21</sup>

### *Optometry Interest and Capacity to Deliver Enhanced Care*

As part of the GRR scheme at the National Optometry Centre, a process of stakeholder engagement has commenced. One of the aims of this research is to evaluate the interest and capacity of optometry to engage in an enhanced primary eye care system. In addition, the Association of Optometrists Ireland has commissioned a number of member surveys, also designed to elicit information of relevance to the care pathways reform initiative. These are important evaluations given the possibility that (i) some optometrists may be comfortable within the current scope of practice; (ii) there may be barriers that limit the possibilities for professional engagement with enhanced care programmes for some optometrists such as the lack of incentive to invest in specialist equipment or means to be remunerated for enhanced services they could immediately begin to provide.

### *Results*

The combined results of the GRR (206 respondents) and AOI (116 respondents) evaluations are summarised in Table 3. In brief, the significant majority of community optometry practices already have the equipment and access to the diagnostic drugs required to operate enhanced eye care schemes for the most prevalent and important conditions including paediatrics, cataract, glaucoma, AMD, diabetes and acute red eye. The majority of practitioners also expressed an eagerness to become involved in such enhanced care schemes. Most practitioners are familiar with and operate electronic practice management systems, and virtually all practices have broadband connectivity that will facilitate electronic communications and direct upload of patient information.

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<sup>26</sup> Mongan A, Kerins F, McKenna B, Quinn S, Mullaney P. Changing trends in postoperative cataract care: the role of electronic patient records in facilitating community optometrist-delivered shared care model in a rural Irish setting. ESCRS, London 2014

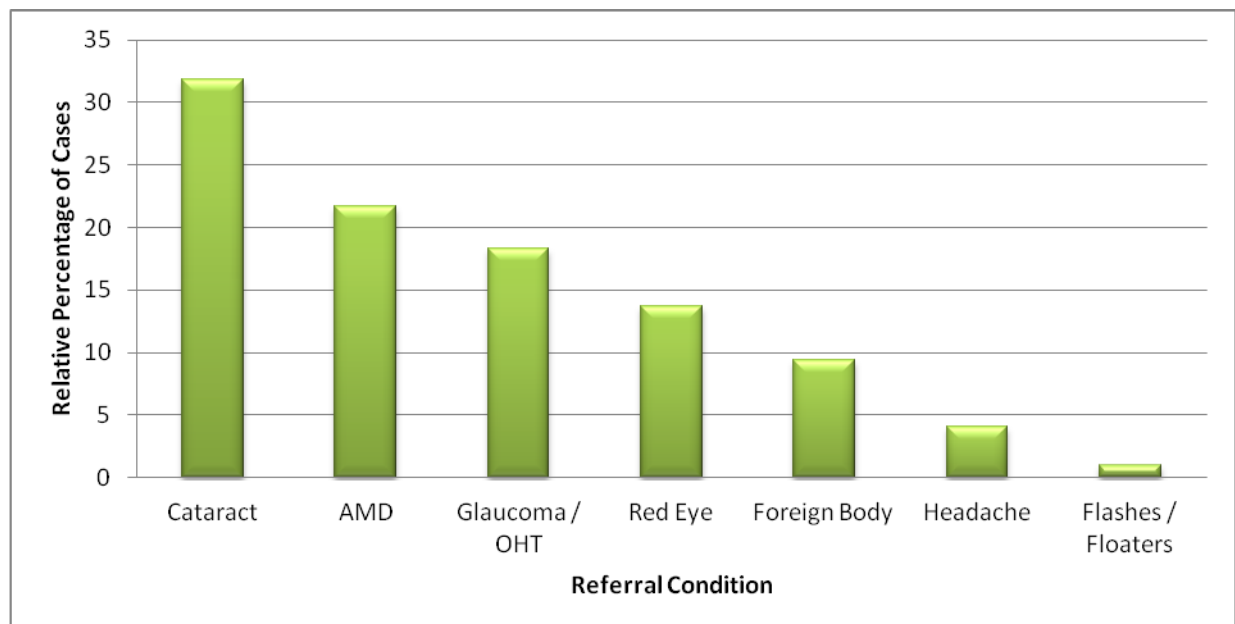
	Percentage of Practitioners	Relevant Care Pathways
<u>Clinical Tests</u>		
Contact Tonometer	52%	Glaucoma
Visual Field Screener	89%	Glaucoma
Volk Lens	78%	Glaucoma, Cataract, Diabetes, AMD,
Pachymeter	10%	Glaucoma
Fundus Camera	72%	Glaucoma, AMD, Diabetes
OCT	12%	AMD, Glaucoma, Diabetes
Slit Lamp Biomicroscope	98%	Acute Red Eye
Child Vision Tests	Sheridan Gardiner 36%; Lea 14%; Kays Pictures 47%; Cardiff 16%	Paediatric
Stereoacuity Tests	84%	Paediatric
<u>Diagnostic Drugs</u>		
Cyclopentolate	79%	Paediatric
Tropicamide	91%	AMD, Glaucoma, Diabetes
Topical Anaesthetic	67%	Glaucoma
Fluorescein	97%	Acute Red Eye
<u>Interest in Enhanced Care</u>		
Paediatric Care	49%	Paediatric
Cataract Care	67%	Cataract
AMD Care	59%	AMD
Glaucoma Care	63%	Glaucoma
Hospital Optometry	44%	All
Independent Prescribing	43%	Glaucoma, Acute Red Eye
<u>Postgraduate Qualifications</u>	Yes = 30%	All
<u>Practice Management System</u>	Yes = 66%	All
<u>Broadband Connectivity</u>	Yes = 92%	All

**Table 4: Equipment and Useful Resources Availability**

#### *Volume of Referrals to Ophthalmology Care*

A recent prospective analysis of referrals from optometry practices was commissioned and conducted by the Association of Optometrists Ireland. Sixty-nine practices took part in the analysis. Out of a total of 4,146 patients examined in the two-week study period, a total of

372 referrals were made to ophthalmology care, a referral rate of 8.97%. The referral conditions and relative frequencies are demonstrated in Figure 3, which demonstrates that the majority of referrals are for the most common ocular conditions in older individuals including cataract, AMD, glaucoma and acute red eye.



**Figure 3: Referral distribution by ophthalmic condition from optometrists to ophthalmology care**

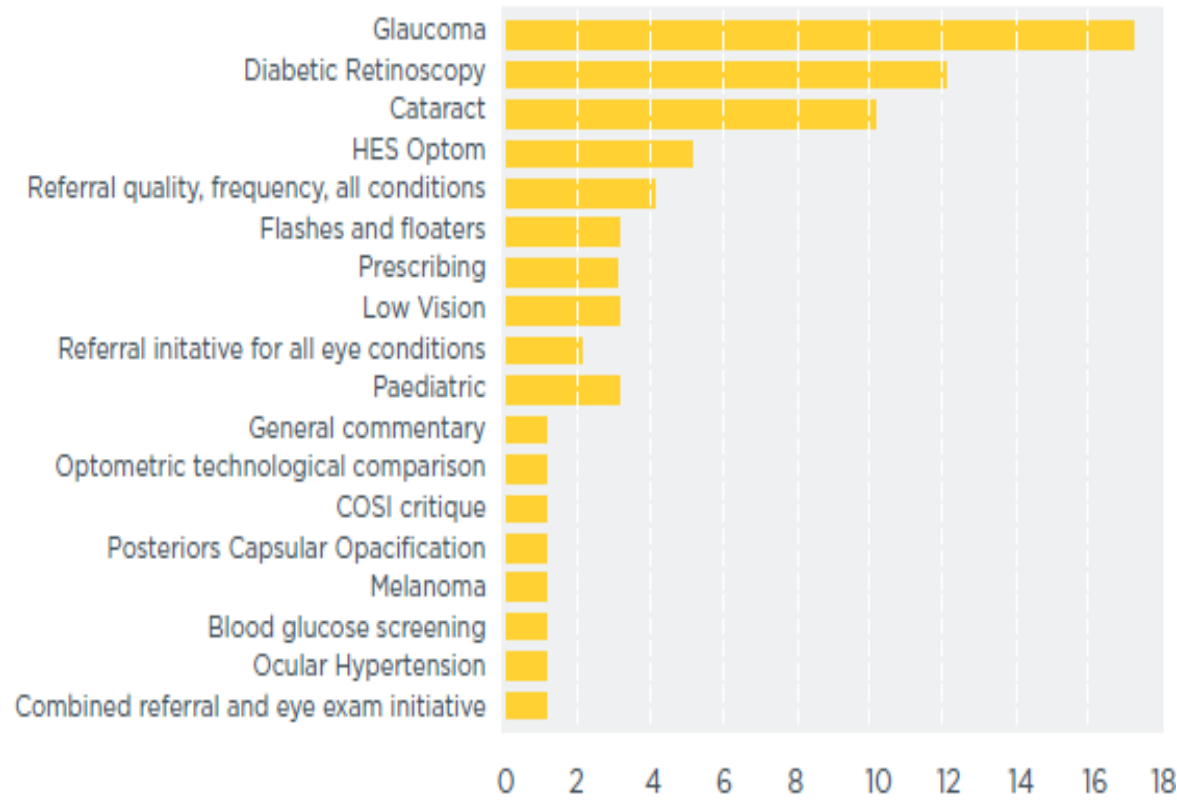
Of these, 52% of patients were medical card holders, with 22% PRSI covered and 26% private fee-paying. An anticipated appointment waiting time in excess of 1 year was reported by 67% of optometrists for routine eye care, and in excess of six months by 87% of optometrists. Scaled nationally, the above figures would suggest that, out of the 424,975 eye examinations conducted by optometrists for patients with medical card or PRSI cover in 2013, approximately 38,120 annual referrals to ophthalmology care would be generated. Approximately 10,000 additional referrals would be generated from private-fee paying individuals, who may or may not decide to opt for referral to a private ophthalmologist. In addition, some 17,500 paediatric referrals would be expected to be generated by the school screening programme. The estimated annual number of ophthalmology referrals, excluding those made by GPs, would be in excess of 65,620 per annum.

#### UK Evidence

Throughout the UK, optometrists (including Irish qualified) are managing an ever increasing number of patients in the community, combining efficiency for the NHS with ease of access for the patient. A recent systematic review of all UK-based research papers on UK Eye Care Services published since 1997 (88 scientific papers included in the meta-analysis) concluded that, where enhanced optometric eye care schemes (including paediatric, cataract, glaucoma, AMD, diabetes, acute red eye, hospital-based and low vision schemes) are implemented and include clear communication channels and referral guidelines, *“the research evidence suggests optometrists provide a safe and high quality service, which is already incorporated within the core skills of their initial degree training.”*<sup>27</sup> The ample body

<sup>27</sup> Hawley C, Albrow H, Sturt J, Mason L. UK Eye Care Services Project Phase One: Systematic Review of the Organisation of UK Eye Care Services. College of Optometrists. 2011.

of research papers (Figure 4) which document the merits of an increased co-management primary care role for optometry in the UK, where optometrist training is on a par with Ireland, provides solid reassurance as to the economic feasibility, quality, safety of and patient preference for such co-management schemes.



*Figure 4: Co-management eye care services research papers supporting an enhanced optometry role <sup>23</sup>*

## Proposed Primary Care Pathways – Priority Areas

Optometry can provide cost effective enhanced primary eye care community services in a manner that optimises the efficiency, quality, safety and outcomes for patients, across a number of key eye care pathways including:

- Paediatric eye care
- Diabetic Retinopathy
- Cataract
- Acute Red Eye
- Glaucoma
- Low Vision Services
- Age-related Macular Degeneration

The commissioning of primary eye care services in the community should be based upon equity of patient access and value for money. For some pathways, such as paediatrics, low vision and acute red eye, many optometrists are already positioned to provide the service without significant investment in training, equipment, infrastructure or IT. For other pathways, key barriers and enablers will need to be addressed in order to implement the enhanced pathways fully, and allow the pathways to evolve in relation to patient needs and as informed by emergent research, monitoring and evaluation systems.

### Paediatric Eye Care

Children's vision is checked during the developmental clinics and all school going children are vision screened by Public Health Nurses at junior/senior infants and 6<sup>th</sup> classes. Children who fail the screening are referred into the public system via the local health clinic. A defined treatment window exists for the condition amblyopia, with successful outcomes dependent on early intervention. Due to long waiting lists there are clear risks that amblyopic children may not receive the treatment they need within that window with the subsequent possibility of having lifelong visual problems. Furthermore, given the close association between vision and learning, prompt intervention is a key priority to avoid any possibility of educational disadvantage for child development.

### *Rationale for change*

Although no data exists on paediatric referral patterns in Ireland, international evidence suggests an expected referral rate in the region of 25-30% per annum,<sup>28,29</sup> which would equate to approximately 17,500 annual paediatric referrals. Assuming a false positive referral rate of 40%, and that each child diagnosed with a visual disorder requires an average of 3 examinations per annum, some 38,500 annual examinations are required just to keep pace with current new referrals only. If all children remain in the public system until age 12, then the annual requirement is in the region of 308,000 paediatric examinations. It is not surprising that waiting lists now extend to 5 years in some regions with just 22 community ophthalmologists struggling to meet the service needs. National figures are also not available for children wait-listed for review in the community ophthalmology service. The data reported in Table 5 is representative of the situation within the country and indicates a substantial threat to child development.

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<sup>28</sup> Krumholtz I. Results from a pediatric vision screening and its ability to predict academic performance. *Optometry*. 2000 Jul;71(7):426-30.

<sup>29</sup> Bodack MI, Chung I, Krumholtz I. An analysis of vision screening data from New York City public schools. *Optometry*. 2010 Sep;81(9):476-84. doi: 10.1016/j.optm.2010.05.006. Epub 2010 Jul 8.

#### Waiting list for Children's Ophthalmic visit in Co. Kildare

HSE Area	New Referrals	Waiting List	Urgent Cases
Naas	975	44 months	1-2 months
Maynooth	887	24 months	6 months
Newbridge	1506	50 months	6 months
Athy	286	47 months	3 months

*Table 5: Waiting list for community ophthalmic visit, June 2013*

The significant majority of referral cases are managed exclusively with spectacle correction, a core competency of all registered optometrists in Ireland. The undergraduate training of optometrists in Ireland includes a comprehensive theoretical and practical paediatric eye care component, in which optometrists develop an in-depth knowledge of paediatric optometry including prescribing criteria, amblyopia therapy, visual therapy and referral criteria. Optometrists are required to demonstrate a systematic understanding of, and competence in, the various techniques for investigating children's visual functions and ocular health. These skills are developed in dedicated paediatric clinics and during supervised practice placement with community optometrists.

Optometrists are also competent in the management of amblyopia, particularly of refractive origin, or when strabismus is accommodative. A range of paediatric CPD events are provided and undertaken by optometrists to facilitate the development of enhanced skills, which are applied routinely (for fee-paying patients) by optometrists in clinical practice in Ireland and within the NHS public health system in the UK. Perhaps the most immediate impact optometry can deliver through primary care pathway reform is for paediatric care, without a need for additional training or significant overhaul of existing systems. By providing for child optical benefit for children through optometrists, waiting lists can be fully eliminated in a short period, and the increasing volume of cases managed efficiently and safely with improved patient outcomes into the future. The proposed care pathway is outlined in Figure 5 below.

#### Proposed Paediatric Care Pathways

There is little evidence to support the continuation of 6<sup>th</sup> class screening, this should be discontinued and efforts focused on providing screening examinations at the earliest opportunity in junior infants. Additional savings would be made if optometrists were engaged to lead the school screening programme through the provision of standardised training to public health nurses, and collation of performance related data to facilitate audit and scheme refinement. The existing national distribution and number of available optometrists, in conjunction with orthoptists where available, would facilitate a national training programme and effective communication links with PHNs. Regulatory changes would also be necessary to facilitate direct optometry referrals to multidisciplinary teams in community clinics.

##### *1: HSE Child optical scheme extended to optometry practices*

Eligibility to child eye services is not equally applied and varies throughout the country. A nationally standardised system that directs all school screening referrals (and existing wait-list) to community optometry participant practices regardless of the age of the child would provide for a substantial improvement in the paediatric service in terms of accessibility,



patient outcomes and waiting list size. Provision would also need to be made for symptomatic children presenting outside of the national screening programme pathway, to ensure that (a) pre-school age children (b) children who pass the national screening test in school despite compromised eye health and (c) older children who become symptomatic in subsequent years after the school screening all have equitable access to have any eye care problems addressed at the earliest opportunity

## *2: Optometrists employed directly in multi-disciplinary teams within community clinics and hospitals*

An additional benefit would accrue from the creation of multidisciplinary teams in the community involving optometrists among other eye care professionals. Integration of the various professions will yield benefits to the professions and to patients, as well as delivering cost savings to the exchequer.

### **Cost Savings**

#### *Estimated Examination Cost in HSE Clinic*

Costs of providing a HSE funded child eye examination in each community or hospital clinic are unknown but include:

- Ophthalmologist Salary
- Administration Costs
- Administrator Salary
- Buildings Costs
- Nurse Salary
- Diagnostic Drug Costs
- Insurance (Buildings, Professional Indemnity, Public Liability)
- Consumables & Overheads

For the purposes of this calculation, a conservative estimate of €100 per examination is estimated, comprising €50 for salaries, and €50 for all other HSE clinic running costs.

Given the need for an initial cycloplegic examination and regular follow-up visits, an agreed scale of examination fees would need to be negotiated. Assuming an agreed rate of €60 per optometrist cycloplegic examination and €40 for follow up non-cycloplegic examinations, this pathway would generate net savings of €160 per patient per annum  $[(100 \times 3) - (60 + 40 + 40)]$  assuming 3 annual eye examinations per child.

Within multidisciplinary teams, the salary rates and associated costs for optometrists would typically be lower than those required for ophthalmologists in HSE clinics. This pathway would generate actual cost savings assuming optometrist salary costs are 33% lower than ophthalmologist (optometrist annual salary ~ €55k plus extras – source: approximate midpoint of senior orthoptist scale). This pathway would generate a minimum cost saving of €23.55 per patient per annum, and provide for additional benefits in terms of releasing community ophthalmologists to manage other conditions in the community such as glaucoma.

There is a current provision for 101,376 annual examinations by community ophthalmologists working at maximum capacity, provided at an estimated annual cost of €10,137,600. Optometrists could deliver the same number of examinations at an estimated cost of €4,730,880, generating an annual cost saving of **€5,406,720**.

Providing the annual estimated requirement of 308,000 paediatric eye examinations within community optometry practices in multidisciplinary HSE teams could be delivered by

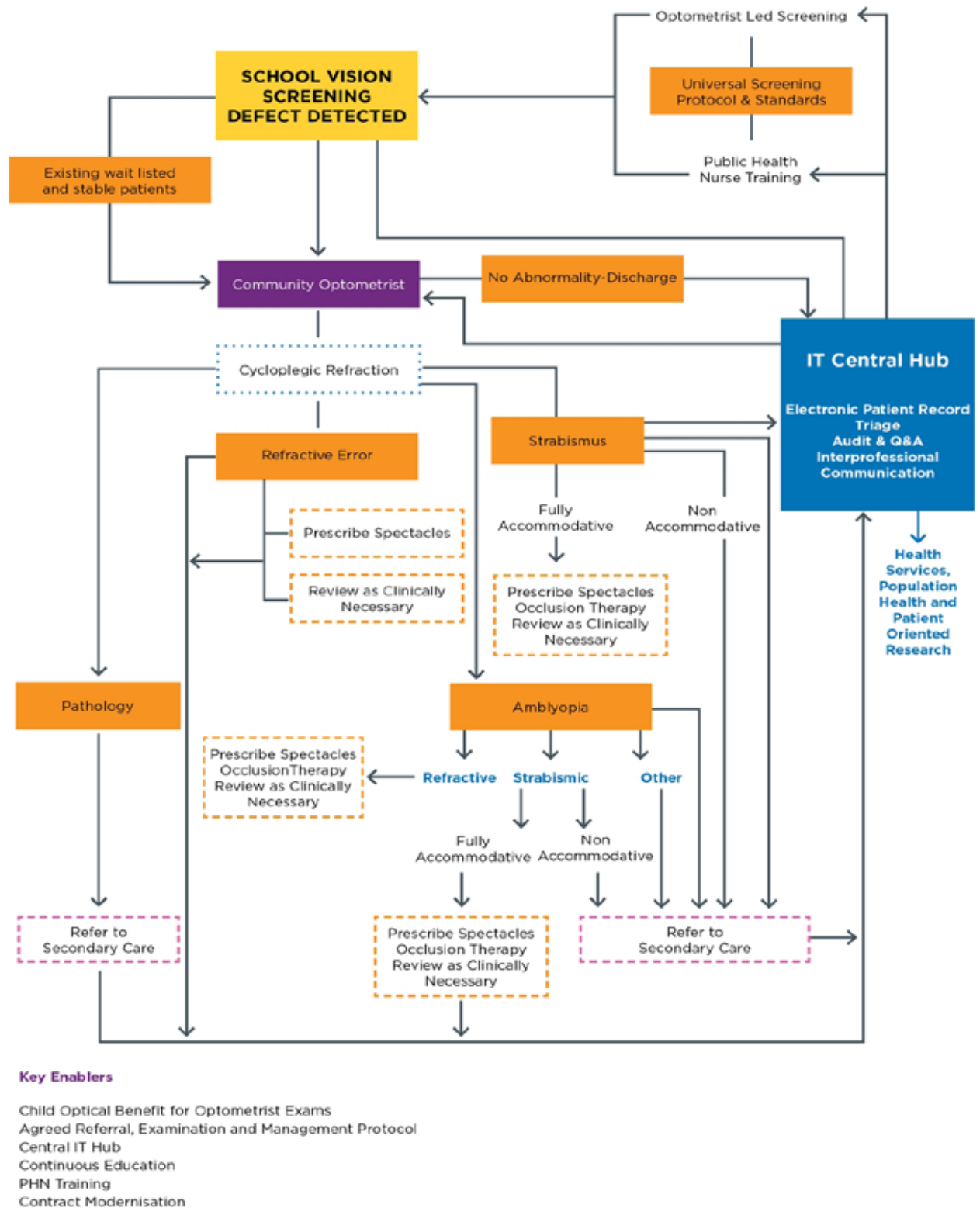


optometrists at an annual cost of €14,373,333, just above the current costs required to deliver only one third of those examinations by community ophthalmologists, and some €12.3 million cheaper than could be delivered utilising community ophthalmologists.

The principal additional benefits, however, would include critical timely intervention, shorter waiting lists for paediatric care, better outcomes for children and the release of ophthalmology resources to manage the most complex cases, and to become engaged in the management of other eye care problems requiring medical intervention. Increased care provision would therefore be delivered through deployment rather than additional training and recruitment in ophthalmology.

**Annual Cost Saving €5,406,720**

## Paediatric Eye Care Pathway



**Figure 5: Proposed Paediatric Eye Care Pathway**

### Cataract

Cataract surgery is a high volume procedure in Ireland, with the numbers of cases treated rising significantly in recent years (see Figure 6), a trend likely to continue given life

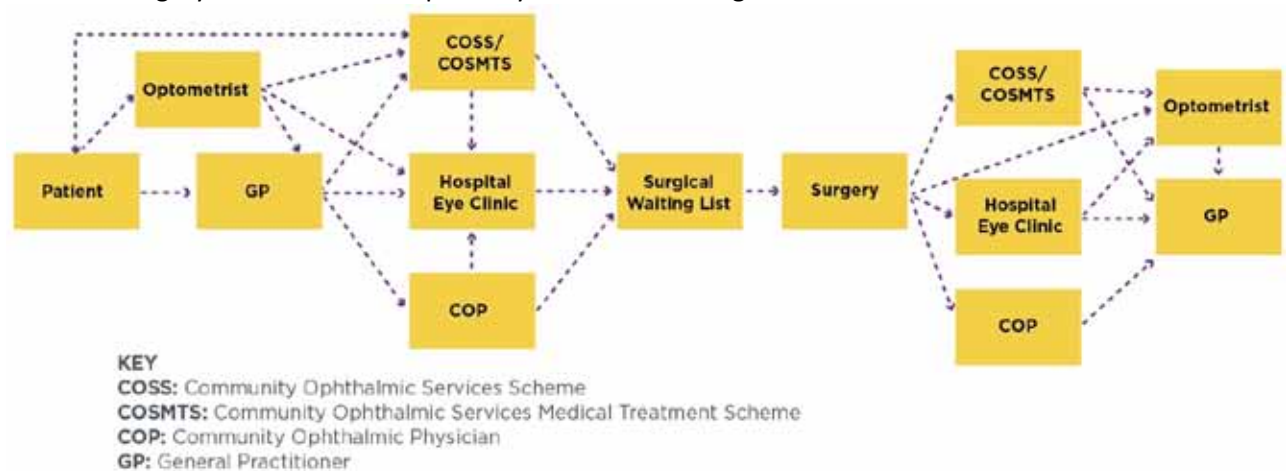
expectancy and population growth trends, coupled with the escalating demands of an increasingly visual society.



**Figure 6: Increase (82%) in patient treatments for cataract 2005- 2012**

#### *Rationale for Change*

The current care pathway for cataract is inefficient and costly, typically requiring patients to attend three or four separate eye care practitioners before a patient has surgery, and also utilising hospital resources for routine follow up, then followed by an optometrist visit for final spectacle correction. Self-referrals to COSMTS ophthalmologists also occur and are not cost effective given the scale of applicable examination fees using this pathway. Optometrists provide in excess of 90% of cataract referrals, and are obliged to refer through the patients GP, after which, a hospital assessment is conducted before a patient is wait-listed for surgery. The current care pathway is described in Figure 7 below.



**Figure 7: Current diagnosis, referral, treatment and follow-up pathways for publicly funded patients undergoing cataract surgery**

Cataract co-management is one of the most straightforward shared-care systems to implement; it is well liked by patients; in audit it has been shown to be effective and to reduce the number of hospital visits from five to one or two. In a well-managed system it is likely that for every three outpatient ophthalmologist appointments saved, one extra cataract extraction can be undertaken. Extended utilisation of optometrists to permit direct surgical wait listing, in addition to provision of post-op care in line with their clinical competence can serve, therefore, to streamline the current care pathway, provide cost savings to the exchequer and release hospital resources to address mounting waiting lists.

### Proposed Care Pathways

#### *1: Community optometrists operate a direct referral system for surgical wait listing*

This pathway will eliminate the need for GP, community ophthalmologist and hospital visits, thereby generating immediate cost savings, release of hospital resources and reduction in GP case load. Direct referral systems in the UK have seen waiting times drop from 15 months to 3 months,<sup>30</sup> and have been observed to provide better information regarding measured vision and 'better delivery of pre-operative counselling'.<sup>31</sup>

#### *2: Community optometrists provide post-operative check up and spectacle refraction at single visit 4 weeks after surgery for uncomplicated cases discharged from hospital*

This pathway offers additional and complementary savings to those generated in the direct referral pathway and releases hospital resources to reduce waiting lists and avoid the necessity for NTPF funded cataract surgery.

### Cost Savings

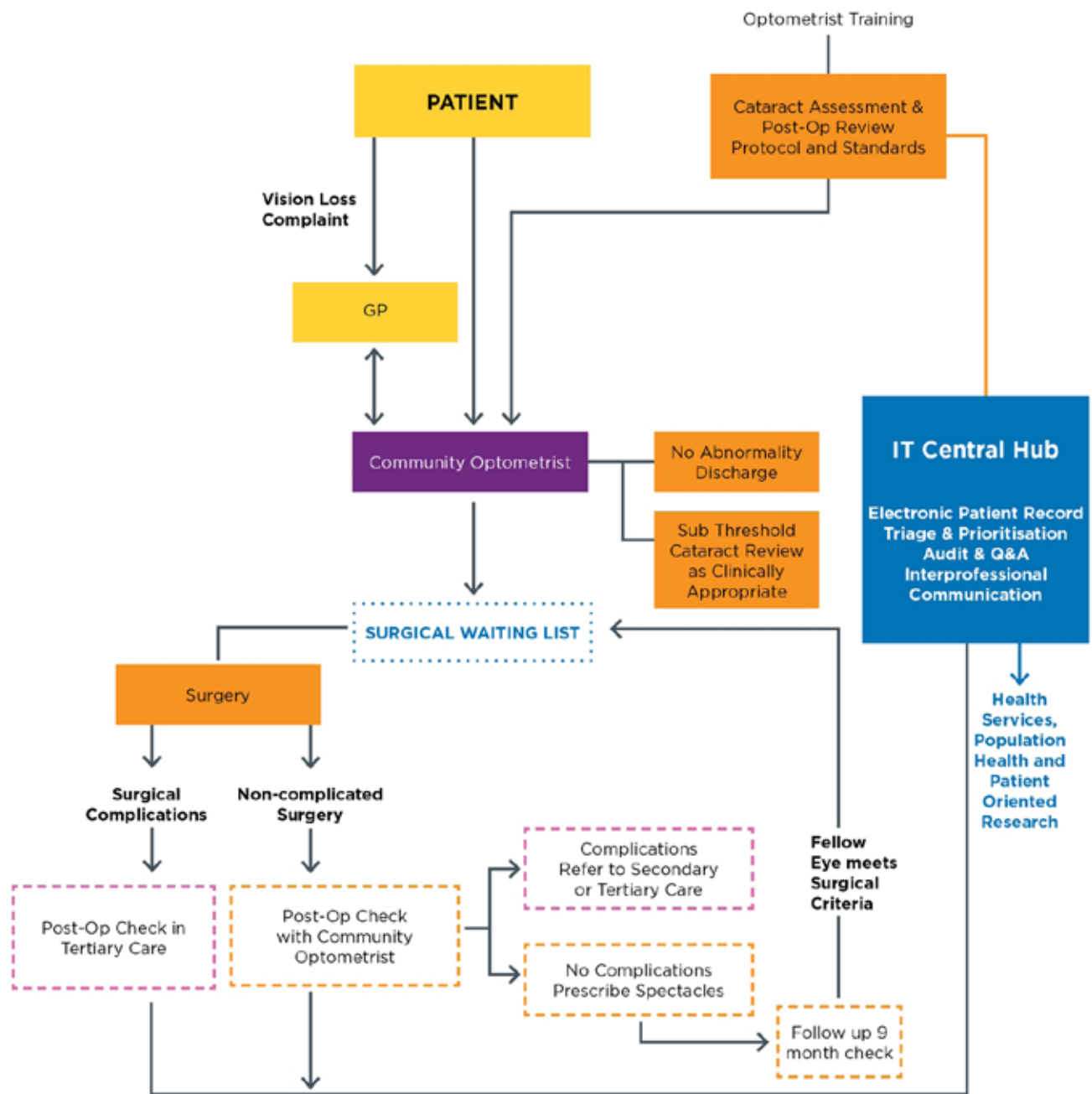
The current cost of each hospital outpatient visit has been estimated at €150. Appropriate fees above the existing €45 dilated examination fee per visit will need to be agreed to cover the increased professional responsibility, insurance costs, IT and reporting, administration time and costs for optometrists to provide the direct referral and postoperative examinations. For the purposes of this calculation, the direct referral eye health examination and postoperative spectacle examination and health check fees are set at €60 each. Conservative overall cost savings for a combined option 1 and 3 therefore are €225.02 per patient ( $€150 - €60 + €22.51$ )\*2 or **€2,692,589** per annum at the 2012 national case load of 11,966 cataract surgical cases.

**Annual Cost Saving €2,692,589**

<sup>30</sup> Newsom W, Gibbons H, Flanagan D, Hingorani M. Direct referral of cataracts in Huntingdon: Sharing good practice. *Optometry Today*, (2005). April, 21-24

<sup>31</sup> Park JC, Ross AH, Tole DM, Sparrow JM, Penny J, Mundasad, M.V. Evaluation of a new cataract surgery referral pathway. *Eye*, (2009);23:309-313.

## Cataract Care Pathway



### Key Enablers

Central IT Hub or Accessible EPR System  
Optometrist Training  
Assessment, Review and waitlisting protocol  
Contract Modernisation

**Figure 8: Proposed Cataract Care Pathway**

## Glaucoma

Glaucoma represents a life-long condition from time of diagnosis, and has been noted to have particularly high prevalence in Ireland, a trend which continues to increase due to the

age-related nature of the condition.<sup>32</sup> Only approximately 50% of current cases of glaucoma have been diagnosed.<sup>32</sup> As glaucoma is a disease with insidious onset, case-finding is typically opportunistic, and almost exclusively by optometrists at routine eye examination visits. Glaucoma ranks as the second leading cause of blindness in Ireland, accounting for 12% of cases.<sup>33,34</sup>

#### *Rationale for change*

Due to the complex nature of the condition, the clinician chair time associated with glaucoma is substantial, far exceeding any other ophthalmic condition. Many patients at risk of glaucoma are not undergoing treatment, but continue to attend outpatient clinics on a six-monthly basis. Suspicion of the condition also generates substantial false positive referral rates into the hospital system. Once diagnosed and treated, the efficacy of current medical management options is such that the significant majority of glaucoma cases are controlled effectively, without detectable clinical deterioration of their condition. Glaucoma therefore is particularly suited to a shared care system, and has proven efficacy data in the UK as perhaps the pathway most widely employed and analysed.

A number of short, medium and longer term initiatives can serve to substantially reduce the hospital case load, and transfer care into the community.

#### **Proposed Care Pathways**

##### *1: Optometrist performs routine repeat measures for suspect cases*

Funding for a repeat measures scheme would be expected to reduce false positive referrals to hospital by 30%. Currently, optometrists are not funded to provide a second examination in order to confirm the presence of suspicious findings including ocular hypertension or visual field loss. Due to the nature of the tests involved, suspect findings disappear in many cases on repeat testing as there is a steep learning curve associated with the patient performing field tests for example.

##### *2: Community refinement of glaucoma referrals by specialist optometrists*

This pathway can reduce secondary care referrals by a further 40%, and keep suspects in the community until and if hospital care becomes necessary. Such specialist optometrists would require dedicated hospital based training to ensure their clinical decision making aligns with existing hospital practice. This service could be provided within community practice or multidisciplinary healthcare teams.

##### *3: Audit of existing hospital patients to identify those suitable for transfer to community care*

This step would dramatically reduce the hospital case load (ocular hypertensives, suspects, and possibly stable glaucoma cases), and also generate significant cost savings per patient per annum. This service could be provided within community practice and multidisciplinary healthcare teams.

#### **Cost Savings**

A repeat measures scheme would generate a cost saving of €130 per patient assuming an optometrist claims the existing dilated exam fee for the initial consultation, and a repeat measures fee of €20 for the repeat measures assessment. Using data from the recent

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<sup>32</sup> Coffey, M., Reidy, a, Wormald, R., Xian, W. X., Wright, L., & Courtney, P. (1993). Prevalence of glaucoma in the west of Ireland. *The British Journal of Ophthalmology*, 77(1), 17–21.

<sup>33</sup> Munier, a, Gunning, T., Kenny, D., & O'Keefe, M. (1998). Causes of blindness in the adult population of the Republic of Ireland. *The British Journal of Ophthalmology*, 82(6), 630–3.

<sup>34</sup> Kelliher, C., Kenny, D., & O'Brien, C. (2006). Trends in blind registration in the adult population of the Republic of Ireland 1996-2003. *The British Journal of Ophthalmology*, 90(3), 367–71.

prospective analysis of optometry referral patterns, the anticipated 7243 public glaucoma referrals would be reduced by 2173, generating cost savings of €282,490 per annum.

Assuming eight referral refinement optometrists provide enhanced eye examinations, a fee of €60, a bi-annual examination, and a maximum capacity for 500 such patients to be monitored by each practitioner, the referral refinement pathway would generate cost savings of €190 per patient ( $€150 + €150 - €60 - €60$ ). Assuming that 40% of patients are transferred to this pathway, an overall annual saving of €760,000 per annum is anticipated.

Assuming that 20 optometrists become engaged in community practice based care of existing hospital patients, and a maximum of 500 such patients could be transferred to each participating optometrist, and a cost saving of €190 per patient per annum, this would result in annual savings of €1,900,000.

The overall estimated cost savings generated by the combination of the three pathways above is €2,942,490 per annum.

**Annual Cost Saving €2,942,490**



# Glaucoma Care Pathway

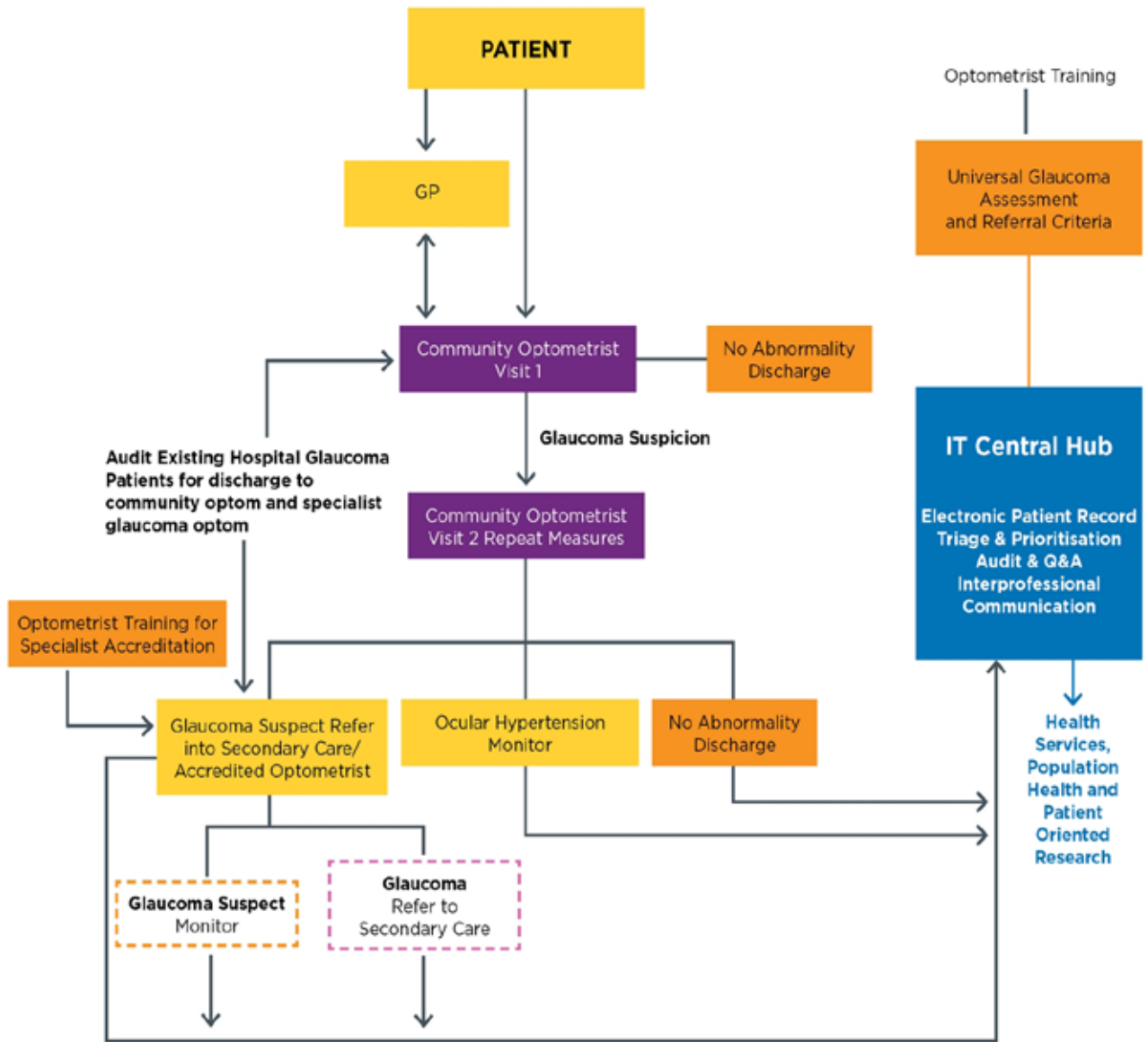


Figure 9: Proposed Glaucoma Care Pathway

### Age-related Macular Degeneration

AMD represents the most common cause of blindness in older adults in Ireland, and is becoming increasingly prevalent as evidenced in the rise in day-case attendees at hospital departments since 2005. This pattern also reflects improvements in treatment options for neovascular AMD patients, which now exerts a significant burden on human and fiscal resources.



Figure 10: Increase in number of AMD day cases 2005-12

#### *Rationale for change*

There are two types of AMD

1. Dry - for which there is no treatment
2. Wet - for which intravitreal injections of anti-VEGF drugs are required by patients from the time of diagnosis for many years.

Patients who are diagnosed with wet macular degeneration need rapid access to eye care. This is the only way they can achieve a good outcome which can potentially save their sight and maintain independent living. The vast majority of AMD cases (circa 90%), however, are of dry AMD, which is untreatable. Currently, there is a requirement that all dry AMD patients are referred to secondary or tertiary care despite the lack of available treatment options. Optometrists are readily placed to monitor dry AMD patients in community practice, and to identify wet AMD cases for fast track referral into hospital care. By keeping the care of dry AMD patients in the community, the capacity for fast track care of wet AMD patients is vastly improved.

### Proposed Care Pathways

#### *1: Optometrist performs gold standard AMD examination including OCT*

This pathway allows for all dry AMD patients, accounting for close to 90% of cases, to remain in community care. Wet AMD (with good residual VA) will remain an urgent referral through a fast-track pathway to secondary or tertiary care that will be facilitated by release of hospital resources through reduced numbers of dry AMD referrals and transfer of existing hospital cases to community care.

#### *2: Audit of hospital dry AMD patients for transfer to community care*

In response to Association of Optometrists Ireland surveys, 16 optometrists have confirmed the availability of OCT for AMD assessment in their practice. As OCT prices continue to fall, and care pathway options open, it is likely that an increasing number of optometrists will become accredited in OCT use and purchase commercially available devices. OCT devices are also available in a number of community ophthalmology private practices.

### Cost Savings

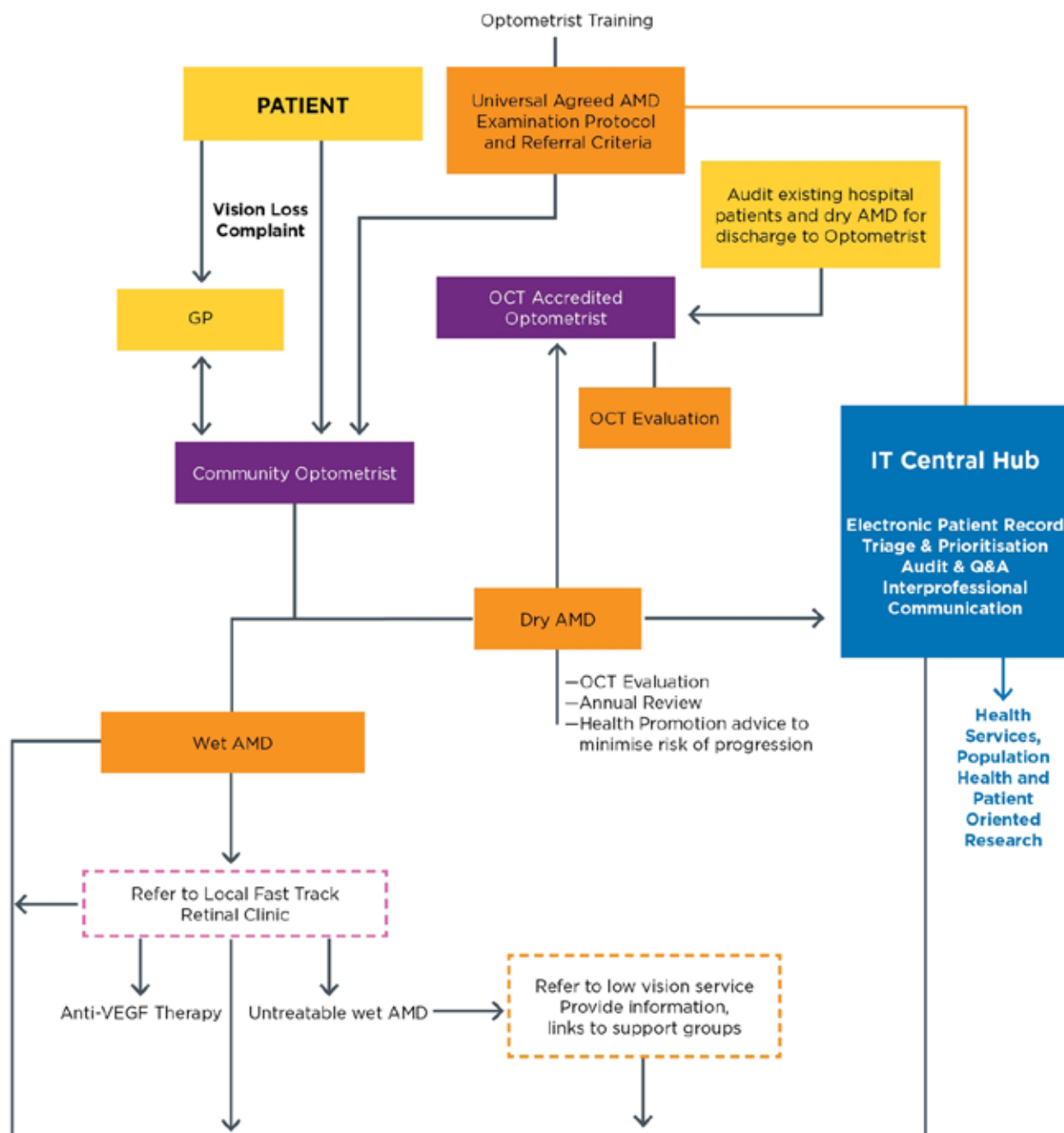
Using data from the recent prospective analysis of optometry referral patterns, approximately 7,212 dry AMD hospital referrals would be avoided per annum. Assuming an enhanced eye exam fee of €60, this pathway would generate a saving of €90 per patient relative to outpatient clinic attendance cost, and a net annual cost saving of €649,080.

Assuming a once annual examination, a maximum capacity of 1000 patients are transferred to each community optometrist following hospital audit, and only these 16 optometrists are involved in the discharge scheme, and a saving of €90 per patient visit, annual cost savings ( $1000 \times 16 \times 90$ ) of €1,440,000 can be realised. Involving non OCT accredited optometrists by employing a gold standard AMD eye health examination without routine OCT scanning (only conducted at baseline) will augment the accessibility of the service and cost savings to be generated. In addition, discharge of stable neovascular AMD cases to OCT accredited optometrists can generate increased levels of annual savings.

The conservative overall estimated cost savings generated by the combination of the AMD pathways is €2,089,080 per annum.

**Annual Cost Saving €2,089,080**

## Age Related Macular Degeneration Care Pathway



### Key Enablers

Central IT Hub or Accessible EPR System  
OCT Training  
Examination and Referral Criteria  
Contract Modernisation

Figure 11. Proposed AMD Care Pathway

### Diabetic Retinopathy

The alarming rise in diabetes prevalence is a global public health and economic problem. Diabetic retinopathy is the most common complication of diabetes and the leading cause of blindness among working-age populations in the Western world. The HSE has recently launched a national diabetic retinopathy screening programme in recognition of the increasing problem of diabetes and diabetes associated visual impairment and blindness open to most diabetes patients in Ireland aged over 12 years. This programme has been launched in recognition of the increasing prevalence of diabetes and its potentially blinding complications. The changing pattern of diabetes diagnosis means that the potential for blindness is significant.

#### *Rationale for change*

Optometrists have been shown to be efficient and cost-effective at delivering a system of diabetic retinopathy monitoring in the community. In the UK there are upwards of 60 schemes in which people with diabetes are seen by community-based optometrists, who work within agreed protocols to examine the retina and refer the patients for ophthalmological evaluation and treatment at the appropriate time. A guidance document for optometrists involved in diabetic co-management, produced by the College of Optometrists, the Royal College of Ophthalmologists, the Royal College of General Practitioners, and the British Diabetic Association (now Diabetes UK), with the support of the Department of Health, demonstrates that the involvement of optometrists in the care of the diabetic patient is well supported by all of the relevant professional and special interest groups.

Optometrists are already positioned to perform annual diabetes eye examinations using gold standard protocol including dilated volk examination and digital fundus photography. Not all diabetes patients will engage with the National Diabetic Retinopathy Screening Programme. Furthermore, many diabetic patients remain as of yet undiagnosed. Optometrists are often the first to notice signs of diabetes during opportunistic eye health examinations. Optometrists should be able to direct diabetes patients to the programme. It is also important that the national screening programme engages with optometrists, and provides clinical feedback to optometrists as primary eyecare practitioners.

### Proposed Diabetes Care Pathways

The national screening programme will remain the primary diabetic retinopathy assessment programme. Additional options are required for those currently attending the hospital service, and for those patients not willing to enter the screening programme.

#### *1. Opportunistic case finding*

The current system should be maintained, whereby an optometrist examines any patient exhibiting clinical signs or symptoms indicative of diabetes using a gold standard protocol including dilated volk examination and fundus photography where available. All newly diagnosed diabetic patients should have a comprehensive optometric eye examination before entering the screening programme in recognition of the fact that, although diabetic retinopathy is the most significant ocular manifestation of diabetes, diabetic patients are susceptible to other eye care problems that may not be detected by screening alone.

#### *2. Patients not willing or able to enter the national screening programme*

Optometrists will encourage universal participation in the national screening programme for diabetic patients, but can provide a gold standard dilated eye examination annually, including volk exam and fundus photography to those unwilling or able to participate.

### *3. Audit and transfer of hospital cases to community care*

Existing mild cases can be transferred to community optometry practices or to community based multidisciplinary teams.

#### **Cost Savings**

The proposed diabetes care pathways have no inherent primary eyecare service delivery cost saving attributes. They will, however, serve to ensure that the prevalence of avoidable visual impairment and blindness due to diabetic retinopathy are minimised, and thereby yield significant downstream savings through a reduction in the direct and indirect costs of visual impairment and blindness and their associated disease burden.

Diabetic Retinopathy Care Pathway

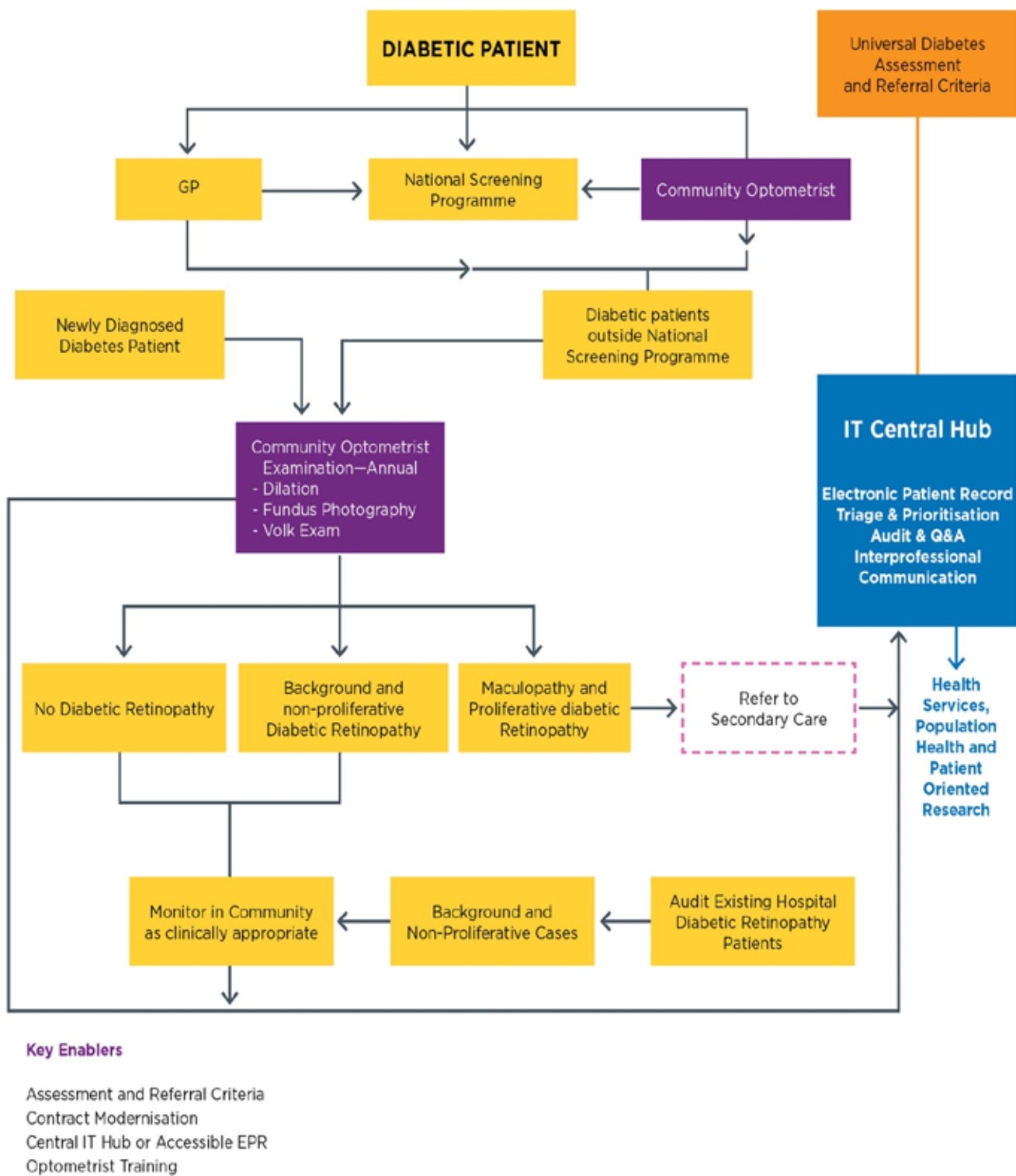


Figure 12. Proposed diabetic retinopathy care pathway



A completely new GOS contract was announced in Scotland in April 2006, the biggest change in NHS eye care for 60 years. The traditional NHS 'sight test', primarily designed for those who require spectacles, was replaced by a comprehensive eye examination appropriate to a patient's needs, symptoms and general health and which may not necessarily include a sight test for spectacles. The new Scottish examination is free at point of use to all patients, whereas previously certain categories of patients were required to pay for the old sight test. The new system also recognises optometrists as the gateway to NHS eye care services and acknowledges the skills and equipment available in community practices.

As part of the introduction of the new eye examination, the Scottish Executive provided each practice with funding of £8,000 for the provision of equipment necessary to carry out the new examinations. Scotland's policy of free eye care is benefiting the country by £440 million per annum, according to a new report published in May 2012.<sup>10</sup> 'The Economic Impact of Free Eye Examinations in Scotland', carried out by 4-consulting and commissioned by the AOP, reveals the introduction of the improved Scottish NHS-funded, universal eye examination in 2006 has led to an increase in the number of people having eye examinations, with a consequent uplift in the numbers of eye problems detected and treated.

Optometry led acute referral services are operational across other parts of the UK and have consistently been shown to be clinically effective, acceptable and accessible, and to be provided at relatively low cost.<sup>11</sup> Through the Welsh Eye Care Initiatives the Welsh Assembly Government has created a package of extended examinations and optometric services to improve patient access to eye care and relieve pressure on overloaded ophthalmic departments in hospitals. The schemes are acknowledged as popular and convenient for patients. A notable success is PEARS – a Primary Eyecare Acute Referral Service - which triages eye conditions. This works well for patients and GPs who do not have the equipment to examine eyes in the same way as an optical practice. Additionally it refines referrals into secondary care, accurately prioritising them. PEARS allows patients to self-refer, or to be referred by their GP, to an optometrist for ocular problems such as red eye, flashes and floaters or sudden loss of vision or onset of ocular pain. A similar scheme is operational in Northern Ireland which was launched following a short course of optometrist training involving online lectures, and accreditation using oral and station exams at the end of the training period.

The evidence suggests that optometrists successfully manage the majority of patients within community practice, which implies that optometrists have the expertise to manage such patients. The majority of GPs receive inadequate ophthalmology training,<sup>35,36</sup> and the shift from GP to optometrist as the acute service provider within a multidisciplinary team should release valuable GP resources for allocation elsewhere.

Acute red eye represents a high prevalence condition that can be managed very effectively using community based optometrists. Even without prescribing rights, optometrists can manage an array of red eye conditions, including dry eye, blepharitis and lid problems, simple corneal abrasions, allergic conjunctivitis, with management rates of 87-96% across these conditions reported in the UK.<sup>37</sup> An acute red eye can occur at any age and can be

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<sup>35</sup> Shuttleworth GN, Marsh GW. How effective is undergraduate and postgraduate teaching in ophthalmology? *Eye* 1997;11:744–50.

<sup>36</sup> Featherstone PI, James C, Hall MS, et al. General practitioners' confidence in diagnosing and managing eye conditions: a survey in South Devon. *Br J Gen Pract* 1992;42:21–4.

<sup>37</sup> Needle JJ, Petchey R, Larensen JG. A survey of the scope of therapeutic practice by UK optometrists and their attitudes to an extended prescribing role. *Ophthalmic and Physiological Optics*, (2008);28:193-203.

extremely painful. Some eyes require immediate treatment, if sight is to be retained, and others are easily treated or require no treatment at all and resolve within a few days. Common causes of an acute red eye include:

Conjunctivitis – viral, bacterial, allergic or occasionally chemical;

Blepharitis – as above, but involving the eyelids;

Subconjunctival haemorrhage ( blood under the outer surface of the eye) –for example, due to minor trauma or, more seriously, due to poor control of anticoagulation treatment – e.g. warfarin;

Corneal abrasion – arising from minor trauma;

Foreign body – potentially a major or minor injury, e.g. - due to an occupational injury such as in welding or, for example, a minor injury due to dust particles in the eye;

Corneal ulcer- arising from infection, trauma or as part of a chronic condition;

Acute glaucoma- as above, or presenting as a painful red eye with reduced vision;

Iritis – an inflammatory condition inside the eye in an otherwise healthy person or as part of another clinical condition; and

Keratitis- an inflammatory condition of the cornea arising from one of several causes.

People with the above conditions will present in a variety of ways such as to a GP, pharmacist or optometrist in primary care or through a hospital emergency department or GP out of hours services. There is no comprehensive source of prevalence data on these conditions in either primary or secondary care. The occurrence of a red eye, however, is a frequent and prominent finding of a disease process in patients,<sup>38</sup> particularly those attending a General Practitioner. The major issue for clinicians is being able to differentiate between the eye conditions which are easily treatable in primary care and those which are potentially sight-threatening and need urgent referral to an ophthalmologist or other specialist practitioner. 'Red eye' may be caused by a wide range of conditions from the benign and self-limiting to the potentially sight threatening.<sup>39</sup> Unfortunately, the symptoms associated with such conditions can be overlapping, and expertise and suitable equipment are key, therefore, to effective management.

#### *Rationale for Change*

UK Guidelines published as Clinical Knowledge Summaries (CKS) by the National Institute of Clinical & Health Excellence (NICE) on behalf of the National Health Service (NHS) call for General Practitioners to refer patients with 'red eye' with a suspicion of a potentially serious condition to be examined by a relevant specialist which according to the NICE-CKS is either an optometrist or ophthalmologist.<sup>40</sup> The current care pathway in Ireland does not include any provision for optometrists to provide an examination of the acute red eye or other ophthalmic conditions under any optical benefit scheme. GPs manage some cases of acute red eye but needlessly refer many cases to hospital outpatients as a GP practice will seldom have access to a slit lamp biomicroscope or other diagnostic instrument that will allow for an accurate differential diagnosis.

The acute red eye example can be extended to other ophthalmic cases presenting at GP surgeries. Optometrists, as previously noted, are the most accessible community eye care practitioner, and are also fully equipped to provide an acute referral triage service, with only

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<sup>38</sup> McDonnell PJ. How do general practitioners manage eye disease in the community? Br J Ophthalmol. 1988 Oct;72(10):733-6.

<sup>39</sup> Ubah JN, Adeoti CO, Isawumi M. Common causes of red eye presenting at an ophthalmic clinic. Niger J Med. 2006 Apr-Jun;15(2):144-7.

<sup>40</sup> <http://cks.nice.org.uk/red-eye>

minimal additional training required. An acute referral triage service operated by optometrists will also optimise patient safety by ensuring that all management decisions are based on a comprehensive evaluation of the presenting case.

### Proposed Care Pathways

#### 1. Acute Red Eye Triage

Acute red eye patients attending optometry or GP practices are often affected by mild conditions that do not require hospital intervention. As GPs typically do not have the equipment and diagnostic drugs, ophthalmic dyes and stains to provide a thorough evaluation of the cause of the red eye, it would be logical to direct all such cases to community optometrists for assessment within the multidisciplinary community team. Optometrists can manage all cases not requiring medical treatment such as topical antibiotic drops. For those cases requiring such medical intervention, a communication to the GP or community pharmacist who is in possession of the patient's full medical history can be used to generate a medical prescription where clinically indicated. Optometry triage of all such patients offers the additional benefit of ensuring that topical antibiotics are prescribed only when appropriate. For those patients requiring a higher level intervention, onward referral to hospital services will be facilitated by the decreased acute red eye case load attending hospital outpatient departments.

#### Cost Savings (Acute Red Eye only)

Optometrists have historically been required to refer cases of acute red eye, irrespective of their ability to manage the presenting condition. According to the AOI survey, 13.67% of referrals were for acute red eye equating to 6,578 referrals annually. Conservatively assuming that 80% of these can be managed in primary care, the cost saving from optometry referrals is €690,690  $[(150-45)*6578]$  per annum for optometry referrals only. A similarly conservative estimate would include a similar frequency of GP referrals, which serves to double the estimated cost saving.

**Annual Cost Saving €1,381,380**

Acute Red Eye Care Pathway

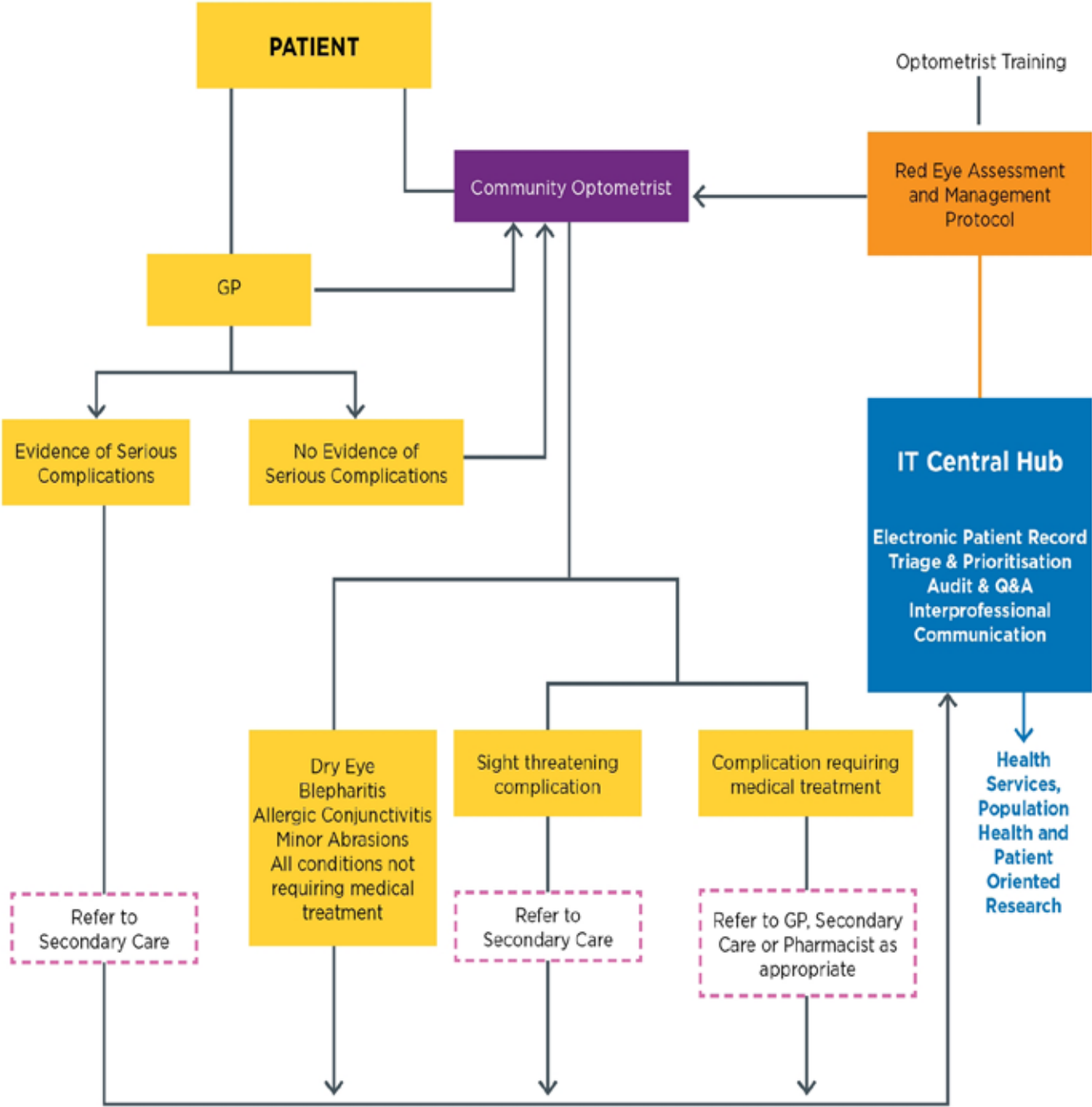


Figure 13: Proposed Acute Red Eye Care Pathway

### Cost Savings Overview

These savings represent the reduced cost of providing the same level of care within community settings. Actual HSE expenditure will likely increase, but will provide a mechanism to deliver far more care within only a moderately increased cost envelope. The major benefits this will yield will be in terms of improved access, reduced waiting times and reduced levels of visual impairment and blindness where the real cost gains will be made over time as is already evidenced in the Scottish model.

	Per Patient Savings	Estimated Annual Savings
Paediatric Eye Care	€160	€5,406,720
Cataract Care	€225.02	€2,692,589
Glaucoma Care	€190	€2,942,490
AMD Care	€90	€2,089,080
Acute Red Eye	€105	€1,381,380
Combined Savings	Average per patient = €166.25	€14,512,259

**Table 6: Overview of anticipated cost savings generated through the proposed care pathway reforms.**

### Clinical Governance

Clinical governance is a system through which healthcare practitioners are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Governance policies that promote a system of collective responsibility by all participants involved in the proposed enhanced primary eye care pathways will serve to optimise the quality and safety levels achieved. In support of the Report of the Quality and Safety Clinical Governance Development Initiative, the AOI and optometry profession would welcome the implementation of clear clinical governance criteria in this regard.

Participants should be trained to the designated standards and protocols and have signed up to them. Formal accreditation mechanisms may be desirable for certain enhanced primary care optometry roles, such as those implemented in the UK e.g. WOPEC in Wales. In keeping with HSE expectations for good clinical governance, all participants in the evolved primary care pathways implemented should:

- know the purpose and function of leadership and accountability for good clinical care;
- know their responsibility, level of authority and who they are accountable to;
- understand how the principles of clinical governance can be applied in their practice;
- consistently demonstrate a commitment to the principles of clinical governance in decision making

The AOI is very much in favour of the implementation of proper and transparent governance systems that create a culture where quality and safety is our collective and primary goal. Such systems should include: (a) the appointment of clinical leads; (b) engagement with patients; (c) formation of management/oversight eye care teams; (d) development of appropriate structures and processes; (e) provision of adequate supports; (f) comprehensive care pathway evaluation; (g) sharing of lessons and experiences among participants. Such systems, as advocated in the HSEs clinical governance framework will ensure that high quality of care and the optimisation of patient safety and satisfaction remain core priorities for optometry and all eye care professions engaged in the evolved primary eye care system.

## Low Vision

Although this document does not set out a primary care low vision service pathway, the issue of low vision services merits brief discussion here.

Patients with low vision are often one of the most disadvantaged groups in society. They are usually elderly and require a dedicated team-approach to their needs. Frequently their social needs are catered for on the basis that their vision cannot be improved but often this is not the case and the provision of low vision aids can dramatically improve their quality of life and independence. The examination of the patient with low vision is an extension of the normal procedures undertaken as part of a routine sight test by optometrists. The provision of low visual aids is a clinical skill, which is well within the remit of optometrists. By working with other agencies, such as Hospital Eye Departments, GPs, Social Services and the voluntary sector, the lifestyle of the low vision patient can be improved significantly, thereby reducing the dependence of that person on others.

An enhanced low vision service provided by optometrists (instead of well-meaning but poorly trained community volunteers) in community practices, within multidisciplinary secondary care teams and in hospitals will deliver best patient outcomes in terms of state and other dependencies.

## Key Pathway Change Enablers

### 1: Information Technology

A successful modernisation and reconfiguration of the delivery of eye care is dependent on the implementation of modern eHealth solutions, which is recognised in the Department of Health's "eHealth Strategy for Ireland 2013" as a critical enabler of best practice health systems and optimum healthcare delivery.<sup>41</sup> Regional IT links are essential for the programme to function to ensure visibility of patient records in community practices, satellite clinics or hospital setting. Implementation of an electronic patient record is essential to facilitate the treatment of patients in the community so that all those involved in treating the patient can view the section of the patient records necessary for their role in the eye care pathway.

An electronic patient record system such as Medisoft or Acuitas which can be made accessible in hospital and optometry practice settings should be implemented on a national basis. To provide a means of secure electronic communication between eye health practitioners, an electronic information transfer system such as "Healthmail" should also be considered for national rollout.

The idea of a Central IT hub has been advocated in each of the care pathway flowcharts listed herein. Such a system would require significant development costs and national rollout costs, but if designed appropriately, could serve a variety of important functions within the eye care pathway. In particular, a national platform to securely store future eye care information that is accessible to eye care practitioners can facilitate the continual evolution of care pathways by facilitating multiple streams of population health, service delivery and patient oriented research. Further, the hub could facilitate enhanced communication across professions and within multidisciplinary teams, and with the appropriate design elements, could provide an automated triage system to manage the onward referral system. Crucially, this system would provide an overall failsafe mechanism whereby patient follow-up is facilitated to ensure no patient falls out of the system following onward referral from one practitioner to another.

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<sup>41</sup> eHealth Strategy for Ireland. Department of Health. 2013

## 2: Contract Modernisation

A modernised primary care contract is required to facilitate more comprehensive integration of optometry as a primary eye care provider. Changes to existing contracts are required for both the HSE and DFSCA contracts which would allow additional/ repeat visits as clinically necessary in order to align with the proposed new referral pathways and protocols. A provision for urgent eye exams without prior approval is also required. A centralised application and payment system for the HSE would help ensure equity of access to service and entitlement, and to facilitate audit, review and statistical analysis which is also essential. A revised fee structure outlined below is one aspect of that contract. A suggested fee structure is proposed herein as a means to allow optometrists to provide four levels of enhanced service supplementary to the existing basic eye examination (see below).

### A. *The Enhanced Eye Health Examination (Band 1)*

This examination fee would apply to comprehensive enhanced eye examinations conducted by participating optometrists:

Paediatric initial cycloplegic examination

Dry AMD monitoring including OCT

Direct referral assessment for cataract

Post-operative cataract review and spectacle refraction referred by hospital

Glaucoma shared care and referral refinement examination

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### B. *Further Investigation/ Examination (Band 2)*

Additional investigations are warranted so that optometrists can further inform their referral, investigate clinical findings or determine best management. This fee will be appropriate for any patient requiring a dilated or specialist eye examination but falling outside of the pathways listed in Band 1

Examples include:

Acute red eye assessment

Follow up non-cycloplegic paediatric eye examination

Disease suspicion requiring dilation or photography such as glaucoma, diabetes or AMD

Diabetic retinopathy annual assessment

Dry AMD monitoring without OCT

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### C. *Repeat Visual Fields Examination (Band 3)*

Patients may be followed-up after they have attended for an eye examination, in cases where there is a suspicion of glaucoma due to possible visual field loss identified at the initial visit. This charge is specific to glaucoma repeat measures assessment and acute red eye follow up visits.

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### D. *Repeat IOP and Red Eye Follow Up Examination (Band 4)*

In cases of suspected ocular hypertension, a repeat Goldmann applanation IOP assessment provides a means to confirm the finding and execute a better informed management decision as to whether to monitor the patient at more regular intervals than otherwise recommended. In certain cases of acute red eye there may also be a clinical need to provide a follow up examination to ascertain the efficacy of the prescribed treatment.



### 3: Hospital based placement of optometrists

Optometry is specifically listed in published HSE recommendations for education and training,<sup>42</sup> which outline the driving, unifying educational ethos that better education and training of health professionals leads to better patient care. Currently in Ireland, optometrists are afforded minimal opportunity for hospital training or experience. An ad hoc system is in place to provide up to 2 weeks training for final year optometry undergraduate students in hospital settings. Some postgraduate students also successfully negotiate placements in hospital clinics, but again on an ad hoc basis. Although optometry students are educated comprehensively in the theoretical aspects of ocular disease, and gain valuable experience in the detection and management of ocular disease both in the National Optometry Centre and during supervised practice placement, the limited exposure to hospital training is not an ideal situation for a number of reasons. Despite optometry being the source of the majority of hospital referrals, the profession remains isolated from the hospital system. There is also an absolute lack of any communication from the hospital system to optometrists. A structured system of increased hospital based training and subsequent hospital employment opportunities would yield multiple benefits including: more substantial understanding of ophthalmological management of the most common acute and chronic eye conditions in community settings; better inter-professional understanding, trust, respect and communication; better experiences and outcomes for patients in and out of hospital settings; and more capacity and better use of resources within hospitals (for example, if refraction, low vision, shared care and other services were delivered by optometrists in hospital, thereby freeing up ophthalmologists for surgery etc).

### 4: Specialist Training & Accreditation

In general, the undergraduate programme of training delivered in Ireland is sufficiently robust such that optometrists have the skills and necessary resources to immediately delivery on some of the pathways outlined herein. For other pathways, minimal training will be required in order to familiarise optometrists with new pathway elements such as agreed case assessment, management and referral criteria, any novel IT systems use or other such changes to current practice. Optometrists are experienced in integrating new knowledge, systems and technology into their practice, so this upskilling can be achieved readily through a programme of continuous professional development as provided by the Association of Optometrists Ireland, Dublin Institute of Technology and other providers, ideally with the input of ophthalmology colleagues where relevant.

Specialist training and accreditation opportunities already exist for the development of clinical skills such as OCT use and interpretation, acute red eye management, and glaucoma shared care among others, some of which require hospital placement and/or virtual clinics for module completion. The North West cataract scheme represents an excellent example of the successful use of short course training to open a new care pathway. The Glaucoma Referral Refinement scheme in Dublin required a more substantial level of training as would be expected for a full shared care pathway, but again was highly successful in its implementation. As mentioned above, a more structured and formal mechanism for optometry placement within hospital clinics would facilitate the enhanced training of optometrists for participation in enhanced service pathways which require a higher level of optometric management. Under CORU legislation, optometrists will have a legal responsibility to ensure that their clinical competence is sufficiently developed to facilitate their clinical practice. There is an onus on participant optometrists, therefore, to ensure

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<sup>42</sup> Education, Training & Research: Principles and Recommendations for Education, Training and Research in the HSE. Health Services Executive. December 2009

their training is sufficient to justify engagement in different levels of enhanced primary eye care service provision.

As new care pathways are rolled out, the Association of Optometrists Ireland will continue to engage with ophthalmology and other eye care partner professions to ensure new continuous training opportunities are provided as required.

#### 5: Assessment, Management and Referral Criteria

Clear operational agreements and guidelines would need to be put in place, communicated to practitioners and facilitated by training where relevant. Ideally an overall national framework would be provided for each pathway, but making provision for local adaptation where necessary. The development of such agreed referral protocols and pathways should take into account the new legislative framework for Optometry (2015) and Orthoptists (2017), with the aim of retaining patients within the community where appropriate to do so, thereby reducing unnecessary referrals and more appropriately managing chronic eye disease within the community setting.

#### 6. Work Force Planning

Revision of work force planning will be required to match the protocols developed and to create an integrated service for patients. This would specifically include the development of multidisciplinary teams who would work in the community clinics, and which would require the introduction of Optometry to the Community clinics and some expansion of orthoptist numbers. This would facilitate the extension of the role of Orthoptists to adult care such as stroke and low vision patients. Each member of the team would have the potential to work to the full extent of their scope of practice and thereby avoid the under use of skilled resource.

#### 7. Infrastructure

Community optometry practices have the required infrastructure to implement many of the proposed care pathway reforms with immediate effect. In order to establish multidisciplinary community care teams, improvements in the equipment provision and facilities at community clinics are critical to the planned retention of patients who can benefit from return to the community from hospital settings.

#### 8: Quality Assurance Mechanisms

Suitable quality assurance (QA) mechanisms would need to be put in place for each care pathway. A central IT hub provides one mechanism to provide overall QA control. In the absence of such a system local initiatives would be required. Electronic log keeping of practitioner management decisions could be used to assess performance, provide continuous feedback and adapt pathways or practitioner involvement as appropriate. Formal accreditation mechanisms may be desirable for certain pathways such as referral refinement or shared care. Evidence of continuous education in relation to such pathways would be useful as a means of ongoing QA. The integration of optometrists within multidisciplinary community teams and on Primary Care Network Management Teams will serve as valuable mechanisms to optimise QA. The appointment of clinical leads for each pathway will also be an important QA control requirement for local and national care pathways.

#### 9. Regulatory & Policy Change

Regulatory and policy change are pre-requisites for the successful implementation of any primary care pathway reforms. In paediatrics, for example, provision should be made for

direct referral of children to optometrists following failed screening. Equitable access should be given to all children under the age of 16 to primary eye care services. Change in legislation is needed to allow direct referral to proposed satellite clinics and tertiary care centres by Optometry, and for those other than medical card holders to be referred to multidisciplinary community clinics. Optometrists should be permitted to refer directly to the COP employed by the HSE as referrals must go through the GP. An audit of the COSMTS scheme after its 10 year pilot is also recommended in order to inform policy decisions in relation to its merits, value for money and suitability for expansion.

#### Additional Primary Care Activities

##### Health Promotion

Health promotion has been described as “the process of enabling people to increase control over, and to improve, their health” and is a key component of public health. It is concerned with the strong links which exist between a person, their environment and their health. It concentrates on the population as a whole rather than just high risk individuals and aims to enable people to take control over, and responsibility for, their health. Optometrists as primary health care providers promote lifestyle choices that protect or enhance good vision and health, facilitated by AOI sponsored health promotion activities.

Health promotion activities could specifically incorporate the following:

- to act as a resource and to participate in the encouragement of children, young persons, parents, unions, industries and the public to practice preventive, protective aspects of eye care and visual processes;
- to inform the public on all aspects of ocular health maintenance, particularly those aspects that place persons visually at risk;
- to inform the media of conditions, events and circumstances that contribute to effective and efficient visual functions and to identify factors that contribute to the occurrence of vision and eye problems;
- to provide understanding of the part played by vision in human development and the caring process, so that maximum potential and efficiency are achieved and maintained in a manner promoting the full enjoyment of life.

The engagement of optometrists in formal health promotion activities from their integrated community base could serve as a key mechanism that can change behaviour in a manner that serves the common goal to reduce the incidence of avoidable blindness. We would encourage the HSE to consider funded health promotion supports to facilitate a coherent expansion of optometry-led health promotion.

## *Appendix 5: Summary & Full Submission from the Federation of Opticians Ireland (FODO)*

### *Summary Submission from the Federation of Opticians Ireland (FODO)*

The Federation of Ophthalmic and Dispensing Opticians (FODO) Ireland represents opticians in business and individual optometrists in Ireland. Our members are passionate about eye health, eye care, patient safety and accessibility to services and believe that the right care, delivered by the right professional, at the right level, in the right place at the right time makes for the most effective use of public resources. We welcome the fact that this consultation clearly recognises the role optometrists and opticians in the community play in primary care, and that they have the potential to play a greater role.

We believe that it is possible to transform primary eye care by improving current practice, by removing or reducing unnecessary bureaucracy and by expanding the role of community optical practices in providing primary care. Our proposals would help to reduce waiting lists, improve patient experiences, tackle inequalities, and free up hospital resources.

#### *Improvements to Current Practice*

At present there is a dangerous lack of consistency in the treatment of children which puts children at risk and must be addressed:

The restriction that prohibits the issuing of optical vouchers to parents of children who present a private optician's prescription rather than a public hospital prescription should be removed.

All children with a high spectacle prescription should be allowed to access a standard increased voucher value.

The application system for children's vouchers should be centralised and brought in line with modern practice and processed online in a similar fashion to adult optical claims.

Children who are identified at the school screening programme as having a suspected refractive error should be referred to community optometrists as the first-line intervention.

The small number who needs hospital intervention would be referred directly to hospital on the basis of a common clinically agreed protocol. The same applies for children with a medical card between the ages of 12 and 16.

#### *Reducing unnecessary bureaucracy*

There should be more direct referral pathways for both adults and children by electronic means. The current system of HSE-funded eye examinations requires a medical card holder to apply for prior authorisation for their sight test from the HSE. Prior authorisation should be scrapped and replaced with a more efficient centralised database and online system.

#### *Expanding the role of community eye care*

Capacity in the hospital sector is limited, whereas capacity in the community optical sector is a great deal more flexible and the skills of optometrists and opticians are currently under-utilised. Subject to proper underpinning by clinical governance and audit, the default should be that whatever services can safely be delivered in the community should be.

Screening services which could be transferred to community optical services in order to reduce waiting times and provide a more convenient and quicker service to patients include school screening and diabetic screening. Other services which could easily, safely and more cost-effectively and conveniently be delivered in the community include cataract referral refinement, glaucoma repeat readings and referral refinement, management of low vision and management of dry eye.

## 1. Introduction

We would like to thank the Primary Eye Care Services Review Group for the opportunity to contribute to this review. We welcome the fact that this consultation clearly recognises the role optometrists and opticians in the community play in primary care, and that they have the potential to play a greater role.

The Federation of Ophthalmic and Dispensing Opticians (FODO) Ireland represents opticians in business and individual optometrists in Ireland. FODO's members include both independent and corporate opticians which operate as primary eye care providers, and individual practitioners. Between them, FODO Ireland members deliver 55 per cent of the eye care by volume and some 425,000 eye examinations a year in Ireland. Our mission is to achieve eye health for all, delivered through world-class services, provided by regulated community-based optometrists and dispensing opticians operating in a competitive environment.

Our members are passionate about eye health, eye care, patient safety and accessibility to services and believe that the right care, delivered by the right professional, at the right level, in the right place at the right time makes for the most effective use of public resources.

Further information about FODO is available on our website <http://www.fodo.com/ireland>.

## 2. Context

This review of primary eye care, which is taking place in the context of wider reform of health and social care in Ireland, as set out in

*Future Health – A Strategic Framework for Reform of the Health Service 2012-15, Report and Recommendations of the Integrated Service Area Review Group* with regard to community health care organisations (October 2014) and the Health Service Executive's *National Service Plan 2015*

is both welcome and timely. The Health (Miscellaneous Provisions) Act 2014 will, when it takes effect, bring optometrists and dispensing opticians within the regulatory ambit of CORU and allow them to take on a greater role within the scope of their skills and experience.

It is against this background that FODO Ireland welcomes and supports the key themes of these strategic approaches.

## 3. Improvements to Current Practice

At present the role of optometrists and dispensing opticians is primarily to carry out sight testing and the provision of spectacles or contact lenses – in short to identify and enable the correction of poor vision in adults.

FODO Ireland suggests the following improvements to help reduce waiting lists, improve patient experience, tackle inequalities, remove unnecessary bureaucracy and free up community ophthalmologist resources to treat patients as opposed to spending time screening:

There is a dangerous lack of consistency in the treatment of children which puts children at risk. Central Statistics Offices (CSO) figures say that by 2021 there will be 200,000 extra children of primary school age<sup>43</sup>. All children under 12 are entitled to an eye examination and a voucher to cover the costs of glasses. In some counties children can only attend the local health clinic to be seen, thereby causing long waiting lists (up to 3 years in Kildare, Wicklow and Meath). If they attend an optometrist privately no HSE voucher can be issued. In other counties (such as Offaly) they can attend an optometrist privately and a HSE voucher can be issued.

The restriction that prohibits the issuing of optical vouchers to parents of children who present a private optician's prescription rather than a public hospital prescription should be removed.

All children with a high spectacle prescription should be allowed to access a standard increased voucher value – at present, practice and values differ from region to region.

The application system for these vouchers should be centralised and brought in line with modern practice and processed online in a similar fashion to adult optical claims.

There is currently a restriction on referring of children from the school screening programme with a suspected refractive error to community optometrists as the first-line intervention. These children should be tested in the community, rather than in a hospital setting where they are subject to waiting lists and other disadvantages. The small numbers who do need hospital intervention could still be referred directly to hospital on the basis of a common clinically agreed protocol.

The same applies for children with a medical card who are between the ages of 12 and under 16. Once a treated child reaches 12 years of age, they are often relisted under a different waiting list. This separate waiting list can again involve long delays, interrupting continuity of treatment and causing poor service provision. Again, these children and transitioning young adults should be primarily managed in the community with hospital care reserved only for the much smaller group that need it. Transition from children, through young people to adults should be a seamless process in primary care with the same clinicians supporting the young people throughout.

The restriction on two year tests should be removed - tests should be based on a frequency recommended by practitioners and service users' perception of their ocular health (subject to advice and guidance from CORU).

There should be more direct referral pathways for both adults and children by electronic means. At present referral for non-emergency cases is via a GP, thus creating an unnecessary step in the process. Approximately six to eight percent of all adult service users are referred onwards via their GP. To the best of our knowledge 100% of these patients are simply referred based on the optometrists' recommendation.

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<sup>43</sup><http://www.cso.ie/en/newsandevents/pressreleases/2013pressreleases/pressreleasepopulationandlabourforceprojections2016-2046/>

The current system of HSE-funded eye examinations requires a medical card holder to apply for prior authorisation for their sight test from the HSE. Prior authorisation should surely not be required for routine healthcare. Moreover, this paper-based system is outdated, inappropriate and costly. Prior authorisation should be scrapped and replaced with a more efficient centralised database and online system. This would result in a streamlined service, a reduction in costs and the provision of a better service to the end-user.

This is already in place for other primary care providers. Pharmacists and GPs for example have an online system in place which allows them to check a person's eligibility for medical card treatment - [www.sspcrs.ie/portal/checker/pub/check](http://www.sspcrs.ie/portal/checker/pub/check). They also have access to an online authorising system in relation to the provision of vaccinations - [www.hse.sspcrs.ie/portal/vaccinations/sec/vacc/Entervacc](http://www.hse.sspcrs.ie/portal/vaccinations/sec/vacc/Entervacc). On this system, a patient's medical card details and PPS number are entered and the system will only authorise the service provider to proceed, if the patient is eligible. This system has an “electronic key” so only registered service providers can use it and to ensure patients' personal data are protected.

### **The case for expanding the role of community eye care**

We believe that optical practices, which provide high quality eye care in convenient locations across the country, can and should play an important part in helping to deliver the vision set out for the health service, in particular:

The requirement to deliver better, more integrated and responsive services to people in the most appropriate setting

That the interests of patients and service users should be put ahead of all other considerations

People should receive the majority of their services, accessed through primary care, in their local community – at the lowest level of complexity that is safe, timely, efficient and as close to home as possible

We recognise that in order to deliver the desired change some degree of organisational change will be necessary. In particular primary care services will need to be developed and delivered in different ways, and there will need to be a stronger emphasis on prevention, early detection and health promotion.

### **Why wider changes are needed**

To date the scope of practice of optometrists – and to lesser extent dispensing opticians – has been severely restricted, largely by section 48 of the Opticians Act 1956 which effectively prohibited optometrists from diagnosing or treating any eye health conditions. This restriction will be lifted once the Health (Miscellaneous Provisions) Act 2014 comes into force. This will mean that optometrists and dispensing opticians will be able to take on a greater role in addressing eye health needs, provided of course that they operate within the scope of their training and expertise.

Good healthcare should focus as much on preventing disease, which often results in savings both to healthcare budgets in the future and the prevention of lost income to the economy, as in treating disease. In addition to the correction of poor vision, the sight test also provides major public health benefits in terms of early detection of eye problems and a range of systemic conditions, such as diabetes or high blood pressure, and helps reduce preventable blindness. Approximately 80% of blindness and vision impairment is avoidable if identified and treated early.



Sight loss and visual impairment are insidious in that they are mainly asymptomatic until serious deterioration has occurred and incidence increases steeply with age. There are currently 225,000 people in Ireland living with blindness or vision impairment, and this is forecast to increase to 270,000 by 2020. Ireland also has an ageing population - the CSO estimates that there will be 200,000 extra elderly people by 2021 and that by 2046 there will be 1.4 million over 65s<sup>44</sup>. The increasing age-related need and advancing technologies which make new sight-saving interventions available (e.g. anti-VEGF drugs to treat age related macular degeneration) mean, that unless skills and capacity are better utilised, hospital eye departments will be over-whelmed and patients will suffer. The only way to cope with this increase in need is to ensure as many patients as possible are

- identified in primary care through early case detection
- referred for rapid assessment, intervention and discharge by the hospital service
- discharged back for routine management and monitoring in primary care.

### **Effective use of resources**

Overall capacity in the hospital sector is limited, whereas capacity in the community optical sector is a great deal more flexible. Optical practices, optometrists and dispensing opticians operate in an open market-driven system. If there is demand, the market will respond. Moreover, the skills of optometrists and opticians are currently under-utilised.

Many patients will consult their GP in the first instance with an eye problem. This not only means that pathologies can be missed (most GPs do not have slit lamps, for example) but also leads to increasing demands on GPs who are already under pressure. Similarly, there are a variety of conditions that are currently identified, treated or managed in hospital that could be managed equally effectively in community optical practices. It would be far better to ensure that pathways are implemented where the optometrist is signposted as the first port of call for patients with routine eye problems.

The obvious solution to the issues of capacity and demand is for optometrists and opticians to provide more care in the community, both within their own skills base and in shared care arrangements with ophthalmologists and other hospital staff. This will meet the Government's health priorities to:

Improve quality and patient safety, with a focus on service user experience

- Promote health and wellbeing –
- Reduce the chronic disease burden
- Enhance and improve service delivery models
- Deliver population based screening programmes
- Improve access to primary care and reduce waiting times.

### **What wider changes are needed?**

Ideally we would wish to see greater access to eye care, in particular amongst low income groups, minority and ethnic groups and older people, all of whom are known to be at higher risk of sight threatening conditions. We recognise that in the current financial climate the resources are not available to extend the scope of free sight tests and screening. However, we believe that more can and should be done to make better use of the existing resources available for primary eye care.

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<sup>44</sup><http://www.cso.ie/en/newsandevents/pressreleases/2013pressreleases/pressreleasepopulationandlabourforceprojections2016-2046/>

Subject to proper underpinning by clinical governance and audit, the default should be that whatever services can safely be delivered in the community should be. By enabling more primary eye care to take place safely in optical practices it will be possible to:

- reduce paediatric waiting lists
- reduce the pressures on busy GP surgeries
- reduce the number of patients with minor or routine conditions who need to be treated in hospital
- reduce unnecessary referrals from primary care to hospitals and
- provide follow up care nearer to home for patients who have received hospital treatment, and
- free-up scarce hospitals resources to cope with the growing pressures from more serious conditions and new interventions.

## **5. Recommendations for primary care services to be delivered by optometrists and opticians**

Given the short timescales for preparing evidence for this review we have not set out any detailed proposals and costings for the delivery of specific services. However FODO Ireland would welcome the opportunity to work with the HSE to develop detailed proposals for the delivery of primary eye care services in the community in all of these areas.

There are certain screening services which we believe could be transferred to community optical services in order to reduce waiting times and provide a more convenient and quicker service to patients. These include in particular school screening and diabetic screening.

### ***Children's Sight Testing and School Screening***

The current system of school eye screening is outdated and needs urgent review in the interests of children's health and development. Currently a public nurse visits schools to screen children for a number of ailments. The rudimentary nature of the eye screening is not sufficient to capture children's sight level adequately. It also fails to determine whether or not there is an underlying problem with the binocular function of that child. Many go undetected, suffer from poorer learning outcomes as a result and go onto adulthood with stigmatising conditions such as amblyopia (lazy eye) and strabismus (squint) which are largely correctable up to the age of 7.

In our view all children should be able to benefit from a proper eye examination in their chosen opticians every two years without having to go through the school system. Assessment by a practising optometrist would allow for a more detailed assessment including with dilation where necessary. Delivering this service in primary care will lead to reduced waiting times in the hospital sector.

### ***Diabetic screening programme***

The diabetic retinopathy screening programme is an area where community optical practices are already proving their worth. When the existing contact comes up for renewal, changes should be considered to enable both the screening and optometric follow-up to take place in community optical practices to improve access for patients.

Other Services.

There is a range of other services which could easily, safely and more cost-effectively and conveniently be delivered in the community utilising the existing core skills of optometrists

and opticians. This includes cataract referral refinement, glaucoma repeat readings and referral refinement, management of low vision and management of dry eye.

There is a very strong case for transferring these services to community optical practices as soon as possible, in terms of making more effective use of the health budget, better use of limited and expensive resources in hospitals, and to provide patients with more convenient appointments (in terms of time and location). We provide an example below – glaucoma repeat readings - for illustrative purposes.

### ***Glaucoma Repeat Readings***

In the UK, the NICE guidelines on the management of glaucoma (CG85 – April 2009) had the side effect of implying that any pressures above 21mmHg be referred to hospital for investigation in the manner described by NICE. Until then, many optometrists had not referred patients who were slightly above 21mmHg if there were no other indication of glaucoma. The number of referrals soared. Although NICE advised investigation where the pressures were repeatedly high as measured by the gold standard of Goldmann contact tonometry, there was no provision within the NHS to fund optometrists to repeat the pressure readings. Although not related to NICE guidance, a similar situation arises where a visual field defect is noted. It is advisable to ensure this finding is repeated and not a one-off before referral, but there was no funding for seeing patients for further appointments.

Glaucoma repeat readings services fund optometrists to repeat pressures twice by Goldmann tonometry and to only refer when the pressure is above 21mmHg in the same eye on both occasions. This has been extremely effective at reducing unnecessary hospital referrals.

In the longer term, and with further specialist training and appropriate supervision it would be possible for optometrists in the community to deliver cataract post-operative checks and follow up, the monitoring of ocular hypertension and low risk (stable) glaucoma monitoring.

## **6. Delivering effective eye care**

### **Ensuring safety and consistency**

Patient safety must always be paramount. Despite being an area of low clinical risk, optometrists and opticians, like all clinicians, must operate within their level of competence and their scope of practice.

Continuing Professional Development (CPD), which will be overseen by CORU when the regulation of optometrists and opticians transfers across to it, has been normal practice in the optical sector for many years. CPD enables clinicians to both maintain and update core skills, but also to add to their skills to meet new demands.

In the UK the College of Optometrists has a system of higher qualifications at three levels which can enable optometrists to take a more advanced role in the community management of conditions such as glaucoma and medical retina. Additionally the College of Optometrists and the Association of British Dispensing Opticians offer higher qualifications in the management of Low Vision. Higher qualifications are currently available for low vision, medical retina, and glaucoma. Further qualifications in paediatrics and primary care are being considered.

## Effective Contracts

If optometrists and opticians are to take on new roles beyond sight testing, new contractual frameworks will need to be agreed and put in place.

Safe and consistent practice should be a requirement of, and be managed through contract specifications. This should include agreed pathways for care, and processes for monitoring and collecting data. This is addressed in more detail in section 7 below.

It will be essential that all contracts are proportionate to the risks involved. In the case of primary eye care, these risks are recognised to be low. Optical practices comprise a mix of large, small and independent providers. The majority of optometrists and dispensing opticians are employed under limited company models and it should be these companies that would hold the contracts.

## Meeting the Costs

We recognise that any service must operate within the total available resource limits. However at present a number of eye care services are delivered in ways that are not cost effective. Too many routine primary care services and screening functions are being carried out using expensive hospital resources.

It will important that the review of primary eye care takes account of how resources are currently delivered and how they could in some cases be better deployed to achieve service transformation.

### 7. Standards and pathways for care

We support the principle that standardised models and pathways of care should be developed for specific care groups within primary care.

Services must be safe, subscribe to a clear set of quality standards, relevant to the needs of the patient and the patient must be empowered to interact with the service delivery system. Different approaches have been adopted in the UK which maximise the use of optometrists and opticians to meet needs and keep public expenditure under control. The training and skills required of optometrists and opticians in the UK are comparable to those in Ireland, and therefore are appropriate models to demonstrate how such services can be delivered safely and effectively.

#### ***Enhanced services in England***

The current review is not dissimilar from the recent *Call to Action on eye health and reducing visual impairment* in England. There the call has been for the commissioning of community enhanced services (which include cataract referral refinement, cataract post operative checks, ocular hypertension monitoring, glaucoma repeat readings, and glaucoma monitoring), which is currently fragmented, to be delivered via a standard national service specification, which includes pathways, accreditation and clinical governance frameworks. Standardised electronic data collection, reporting, clinical audit, performance monitoring and evaluation of outcomes are integral to the process.

A number of eye care pathways, based on best practice, have been developed to enable the core skills of optometrists and opticians to be utilised to reduce unnecessary referrals to secondary care. This includes services for minor eye conditions, glaucoma repeat readings, and cataract referral refinement. Cataract post-operative checks and the monitoring of

ocular hypertension both utilise the core skills of optometrists, whereas other services such as monitoring of patients with low risk glaucoma require optometrists with higher qualifications and/or arrangements for supervision by an ophthalmologist.

The English Local Optical Committee Support Unit (LOCSU) has developed clinical training packages and implementation tools to assist with the commissioning and governance of services based on these pathways,<sup>45</sup> and has produced a map of community eye health services in place across England<sup>46</sup>.

### ***Primary care service in Scotland***

In Scotland the system includes:

- a national eye examination (with defined tests that are age and disease targeted)
- a national referral refinement and disease/condition monitoring service with a supplementary examination.

More significantly, patients with all eye problems go to an optometrist first for evaluation, triage and referral, via a hotline phone within 24 hours if it is considered urgent. This means that GPs no longer see patients who have problems related to their eyes and walk-in eye casualty centres in secondary care have been shut.

Referrals are direct to secondary care, and the patient sees the appropriate specialist on their first visit. Electronic referral will be introduced in the near future.

All of these activities are within the core competencies of optometrists. This system has reduced the number of referrals to hospitals and the savings to secondary care have been calculated conservatively at £55m per year.

The scope of practice of optometrists in Scotland will extend further in the coming years. 25% of optometrists are qualified or currently in training to undertake independent prescribing. And Scotland will shortly move to the discharge of patients with stable glaucoma, diabetic retinopathy and macular degeneration for monitoring by optometrists in the community.

### ***Primary care service in Wales***

In Wales, National Schemes such as the Welsh Eye Care Service (WECS) and its predecessor Primary Eye Care Assessment and Referral Service (PEARS) have seen a steady decline in the number of referrals being made into secondary care despite the ageing population. The chief pathway for achieving this has been in primary care assessment and management of acute eye conditions and referrals from other professionals such as GPs and Pharmacists.

More recently, the Welsh Government has encouraged each of the Health Boards in Wales to bid for additional funding to assist in the delivery of services in primary care. There are well established pathways for referral refinement in cataract and glaucoma alongside a general referral triage service which involves an optometrist working alongside consultants to grade all incoming referrals to secondary care and return many to the community where they can be managed by WECS accredited optometrists.

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<sup>45</sup> <http://www.locsu.co.uk/community-services-pathways/>  
<http://www.qualityinoptometry.co.uk/>  
[www.locsu.co.uk/training-and-development/enhanced-services-training](http://www.locsu.co.uk/training-and-development/enhanced-services-training)

<sup>46</sup> [www.locsu.co.uk/community-services-pathways/community-services-map](http://www.locsu.co.uk/community-services-pathways/community-services-map)

In addition, a well established community based low vision service exists throughout Wales using optometrists to assess, manage and counsel patients who have lost their vision.

Accreditation and audit of all these schemes and pathways is rigorous with much published data. The bulk of the work has been undertaken by WOPEC (Welsh Optometric Postgraduate Education Centre), Cardiff University and the Health Boards.

FODO Ireland

12 December 2014

## *Appendix 6: Full Submission from the Irish Association of Dispensing Opticians (IADO)*

### **Introduction**

The Irish Association would like to thank you for the opportunity to take part in this review. As dispensing opticians, with our optometry colleagues, we are the main providers of spectacles to both adults and children.

The adult scheme is a little outdated with the necessity to make paper application and reliance on sending through the post or presenting to the optical section of our customers health centre.

The children's scheme has seemed to take a backward step with the requirement that to avail of the child's entitlement voucher, the child is required to attend the Community Ophthalmologist for testing.

We would like to outline some changes that we feel would enhance the ability to provide these services.

### **The Background to the Irish Association of Dispensing Opticians**

The Irish Association of Dispensing Opticians represents the majority of dispensing opticians providing spectacles and contact lenses to the general public in Ireland.

The Irish Association of Dispensing Opticians members work in different practice environments which include small to medium sized independent owned optometric practice and multiple owned or franchised high street opticians.

The object of the Irish Association of Dispensing Opticians is to support and advance the character, status and interests of dispensing opticians. Membership of our association allows for the following services:

- Advice to members.
- Continuing education and training.
- Professional indemnity insurance.

### **Outline of the Role of a Dispensing Optician**

Dispensing opticians always place the welfare of the public, who require their professional services, before all other considerations. They maintain a high standard of behaviour, integrity and competence, bringing to bear all their knowledge, skills and expertise in serving the public.

All dispensing opticians have a duty to maintain and develop their professional competence throughout their careers, since only in this way can they continue to offer the best possible service to the public.

Dispensing opticians continue to improve their skills by participation in continuous education and training programmes provided by the The Irish Association of Dispensing Opticians.

It is a contractual requirement that all dispensing opticians in practice and others under their supervision are covered by an appropriate level of professional indemnity and products liability insurance when attending to customers or patients who are entitled to spectacles under the Health Service Executive or Social Welfare Benefit programmes.

Every registered dispensing optician has a statutory duty to immediately refer a patient to a registered medical practitioner or directly to a hospital for appropriate medical advice if it appears that a patient is suffering from disease or injury of the eye.

A domiciliary service is intended for those who are house-bound. A registered dispensing optician offering this service should ensure that the required high standards of care, conduct and professional responsibility are provided. The dispensing optician ensures that all patients are fully advised of their needs for spectacle frames and lenses, all spectacles are properly measured for fit and are fitted to the patient and are checked against relevant standards.

### **Function of a Dispensing Optician**

Dispensing opticians ensure the following when dispensing or supplying spectacles to the patients:

1. The purpose and function of the appliance is fully and clearly explained to the patient and should be suitable for their particular needs.
2. Facial, frame and other appropriate measurements are taken as necessary and recorded prior to ordering the appliance.
3. The spectacles are appropriate, accurate, CE marked and of an appropriate quality.
4. The finished spectacles are checked on the patient for fit, function, and comfort and any necessary adjustments made before they are taken from the practice. This may include checking against a letter chart to ensure the correct acuity is obtained.
5. Patients know and understand the financial costs of the professional services and products offered before they are asked to commit themselves to payment.

### **Supplementary Services Offered by Dispensing Opticians**

Registered dispensing opticians offer their patients other supplementary services to meet particular needs. If the registered dispensing optician is satisfied that he/she possesses the necessary knowledge, either by existing training and examination or by additional knowledge and skill acquired through continuing education and training, such services could include:

1. The provision of contact lenses.
2. Low vision assessment, advice and dispensing.
3. The provision of and advice on eye protection appliances.

### **Recommendations**

- Using the current registered opticians to reduce waiting time for children's eye care services.
- Introduction of online application and authorisation platform for adults.
- Removal of out-dated paper system.



## *Appendix 7: Summary Submission from the Irish College of Ophthalmologists (ICO)*

The ICO is the training body and professional body for eye doctors in Ireland. The College's mission is to advance developments and improvements in eye health and patient safety by; providing the highest standards of excellence in the training and on-going education of Eye Doctors and other Medical Practitioners, advocating on behalf of patients through policy guidance to Government, Health Care Providers and State Agencies, collaborating with patient support groups on shared goals and educating the public to help increase awareness of good eye care practices.

The ICO has partnered with the HSE in developing a Model of Care as part of the National Clinical Programme for Eye Care (NCP). The document, part funded by the ICO, is in keeping with government policy for integrated care, and proposes a rebalance of access to and delivery of eye care services from overburdened acute hospitals to an appropriate community care setting. Following extensive consultation with all of the stakeholders and building on detailed analysis and research, the programme has concluded that a decentralised community based model with clear pathways of referral into secondary and/or acute hospital care should be developed.

In line with the NCP, the College sees an expansion of role for medical ophthalmologist and has developed a new training programme for the specialty. Competencies are integral to the new programme along with higher standards, higher level of skills and leadership. Quality assurance, clinical governance and patient safety of the education programme are priorities for the College. The programme is aligned to requirements in the community service. Training will be delivered across the acute and community setting. The long delay in getting first appointments in OPD is detrimental to patients especially if vision loss results and the option of piloting the proposed pathways in level 2 hospitals should be explored.

The ICO's view is that with agreement on defined care pathways and the provision of additional resources for required diagnostic equipment and facilities, community ophthalmic physicians can have an increased role in providing glaucoma, retinal and medical care. However, not all medical ophthalmology can be delivered in the primary care setting and there needs to be a good integrated model of care. ICT systems are fundamental to the development of integrated services including electronic referrals.

The ICO and the Clinical Care Programme for Eye Care identify the two main issues with the current school vision screening programme as lack of capacity and specificity. Their proposed solutions are (a) referral refinement via establishing referral protocols and providing a screener education programme (possibly via online modules) and (b) developing a team based approach with ophthalmologists, orthoptists and optometrists. The treatment plan for each child will be determined with input from all team members, with clinical leadership given by the ophthalmologist. Children with neuromodulatory disease (strabismus/amblyopia) require medical, orthoptic and optometric treatment until age nine. Once visual acuity is adequate they may be discharged. Children over the age of nine are outside the treatment window for the correction of amblyopia and strabismus and correction through refraction is the only treatment option available.

## *Appendix 8: Summary Full Submission from the Irish Hospital Consultants Association (IHCA)*

### *Summary Submission from the Irish Hospital Consultants Association (IHCA)*

#### **The Community Ophthalmology Services Scheme (COSS):**

- General view is that the underlying concept of the COSS is good but needs to be properly staffed, equipped and resourced.
- An increase in the number of community ophthalmic physicians would be required.
- There is a question about whether the scheme would attract the calibre and numbers required with current salary levels.
- The scheme is currently only available to medical card holders and should be made available to a broader patient profile.
- There may be concerns around clinical governance. Appropriate safeguards would have to be introduced in this regard.

#### **The Community Ophthalmic Surgery and Medical Treatment Scheme**

- The scheme should be either rolled out on a national basis or discontinued.
- The scheme has been implemented in just six areas and this is considered inequitable from a patient perspective.

#### **Role of Optometrists in the Community**

- Children are entitled to a voucher for spectacles which sometimes can only be obtained at a hospital clinic because of poorly developed local services. This represents an inappropriate use of second and third level clinics.
- After the age of visual development (over age 8), children should be able to go directly to a Community Optometrist to be refracted and provided with the appropriate voucher.
- Children under age 8 should attend an Ophthalmology clinic at least initially, but could then be referred on to the Community Optometrist.

#### **ICT and communications generally between professionals in the system**

- Enhanced ICT and communications require increased resourcing and funding.
- Ophthalmic practice centres on photographs and other diagnostics lend themselves to electronic storage and transmission.
- Software is available and it would be reasonably straightforward to create a network through which the entire country would be linked up.

#### **The interface between community and acute hospital services**

- Community ophthalmologists should have some sessions in 2nd and 3rd level hospital clinics to provide a link between hospital based services and community services.
- Potential to improve standards and facilitate the referral of complex patients into the hospital system while more straightforward cases can be referred back out.

#### **Development screening and school screening**

- Increased development and school screening requires an increase in the number of Orthoptists.
- Suggested that screening should not continue past age 11 as it has no proven value.
- There should be a programme of regular retraining of screeners and an audit of outcomes.

- Certain models have been suggested for developmental vision screening and the referral pathways. These are set out in detail in the Association's full submission.

#### **Eligibility for children aged 12+**

- In general children 12+ should be followed up by the local optician. Unless by virtue of their condition such follow up is not satisfactory.

#### **Development of algorithms to support GPs in decision making**

- Algorithms for a selected number of eye conditions are reasonable.

#### **Suggested activities that could be performed in the community following consultation with hospital consultants**

- Follow up of chronic eye conditions.
- Post-surgical follow up (particularly cataract surgery) with electronic feedback of results to surgeon.

### **1. The Community Ophthalmology Services Scheme (COSS)**

The general view among our members is that the underlying concept of the COSS is good. The COSS could potentially reduce the burden on hospital services but clinics need to be properly staffed, equipped and resourced. Members have commented that the Scheme is gravely underfunded.

For example, there are just 2.5 w.t.e. Community Ophthalmic Physicians in the entirety of the HSE South region and Community ophthalmologist services are poorly developed in many areas. An increase in the number of Community Ophthalmic Physicians would be required. However, there is a question about whether the Scheme would attract the calibre and numbers required with current salary levels.

Members also expressed concern that the Scheme is currently only available to medical card holders and that it should be made available to a broader patient profile.

Some concerns were also expressed around clinical governance and questions about who is ultimately responsible for patients. Appropriate safeguards would have to be introduced in this regard.

### **2. The Community Ophthalmic Surgery and Medical Treatment Scheme**

There is a view that the Scheme should be either rolled out on a National basis or discontinued. It has created some level of discontent and disharmony among Community Ophthalmologists as the Scheme has been implemented in just six areas and this is considered inequitable from a patient perspective.

### **3. Role of Optometrists in the community**

Certain concerns were expressed about community ophthalmology services. For example, children are entitled to a voucher for glasses which in many instances can only be obtained at a hospital clinic because of poorly developed local services. This represents an inappropriate use of second and third level clinics. Some members expressed the view that,

after the age of visual development (over age 8), children should be able to go directly to a Community Optometrist to be refracted and provided with the appropriate voucher. Children under age 8 should attend an Ophthalmology clinic at least initially, but could then be referred on to the Community Optometrist.

#### **4. ICT and communications generally between professionals in the system.**

Members are very much in favour of enhanced ICT and communications systems but this requires increased resourcing and funding. The area presents good opportunities for enhanced ICT because ophthalmic practice centres on photographs and other diagnostics that lend themselves to electronic storage and transmission. There is good potential in the area because software is available and it would be reasonably straightforward to create a network through which the entire country would be linked up. Similar systems are already operational in other specialties such as Radiology.

#### **5. The interface between community and acute hospital services.**

There is a view that Community ophthalmologists should have some sessions in 2nd and 3rd level hospital clinics to facilitate continuing medical education, and provide a strong link between hospital based services and community services. Community ophthalmologists practising in peripheral areas are slightly exposed and risk becoming isolated. It would be useful for them to have links with the wider group as it improves standards and facilitates the referral of more complex patients into the hospital system while more straightforward cases can be referred back out.

#### **6. Development screening and school screening.**

There is a view that increased development and school screening would require an increase in the number of Orthoptists. However, it has been suggested that screening should not continue past age 11 as it has no proven value. In addition, there should be a programme of regular retraining of screeners and an audit of outcomes.

In terms of developmental vision screening and the referral pathway if an issue is detected, the following model has been suggested:

Primary Screen:	Nurse (Public Health – trained in vision assessment by Orthoptist
Secondary Screen:	Orthoptist
Tertiary Assessment:	Eye Doctor and Orthoptist

In terms of School vision screening and the referral pathway if an issue is detected, the following model has been suggested:

Primary Screen:	Public Health Nurse (trained by Orthoptist)
Secondary Screen:	Orthoptist
Tertiary Assessment:	Eye Doctor and Orthoptist
Orthoptist monitors treatment	
Yearly Refraction and Orthoptist	

**7. Eligibility for children aged 12+**

In general children 12+ should be followed up by the local optician. Unless by virtue of their condition such follow up is not satisfactory.

**8. Development of algorithms to support GPs in decision making**

Algorithms for a selected number of eye conditions is reasonable.

**9. Suggested activities that could be performed in the community following consultation with hospital consultants.**

- Follow up of chronic eye conditions.
- Post-surgical follow up (particularly cataract surgery) with electronic feedback of results to surgeon.

## Appendix 9: Submission from the Directors of Public Health Nursing (DPHN)

1.	<p><b>What is working well in PHN Pre School Vision Screening?</b></p> <ul style="list-style-type: none"> <li>Galway – All PHNs completed PAC training. Parents report long waiting lists but satisfied when they receive the service.</li> <li>Clare - All children are offered vision screening during core child health visits. This is completed by PHN who has completed PAC training. Any deviations are referred to initially to AMO and then to Ophthalmology Clinic.</li> <li>Longford Westmeath – Locally agreed referral criteria/dedicated child health PHNs/regular training and updates from the orthoptist/regular information on waiting lists.</li> <li>South Tipperary – Majority of referrals by the areas PHNs deemed appropriate by the Consultant Ophthalmologist. Family history considered priority as relevant.</li> <li>Dublin South West – Preschool development assessments i.e. observation, inspection and red reflex using pen torch as per Best Health for Children (2005).</li> <li>Laois Offaly - PHN screening provided at all Core Child Health Visits except vacant areas</li> <li>Cork North Lee - Early referral for treatment. Early detection and follow up at other developmental checks.</li> <li>Roscommon - Clear screening guideline (BHFC 2005), referral criteria and pathway.</li> <li>Donegal - Screening for squint is part of preschool developmental assessments. PHNs have direct referral to HSE Ophthalmic Service and knowledge of family history. Children referred for squint remain review list - this is safe and good practice.</li> <li>Sligo – Standard PAC training and training updates have been beneficial for staff.</li> </ul>
2.	<p><b>What is working well in PHN School Vision Screening?</b></p> <ul style="list-style-type: none"> <li>Galway – Dedicated school PHN with training knowledge and expertise in vision screening and referral pathways. Early detection of vision defects that parents may not be aware of. LogMAR screening Tools. Opportunistic screening in conjunction with other roles in schools.</li> <li>Clare – Dedicated School PHNs facilitate screening and early detection in Junior Infants and 6<sup>th</sup> Class. Over 9 years old are referred to private opticians following referral from school screening. High uptake of screening programme. Dedicated nurse attends Ophthalmology clinic with Community Ophthalmic Physician.</li> <li>Longford Westmeath – Dedicated school PHNs/regular training by skilled personnel/written referral criteria.</li> <li>South Tipperary – Designated schools nurses – expertise honed. Efficiency gains.</li> <li>Dublin South West – Examination in school using LogMAR equipment, the children respond well as they are familiar with the PHN and like the pictures.</li> <li>Laois Offaly - The School Screening PHN completes the Screening at the designated times.</li> <li>Cork North Lee – Early detection of squints and early referral.</li> <li>Children over 9yrs referred directly to private opticians which accelerates their treatment.</li> <li>Roscommon -Clear screening guideline –BHFC. Use of gold standard screening tool – LogMar. Clear referral criteria and pathway. Meets criteria for screening service.</li> <li>Donegal - Service facilitates eye screening in schools. Good uptake of screening. Clear referral pathway and referrals normally seen within 6 – 12 weeks, with report provided.</li> <li>Linkages with Ophthalmic Clinic if concerns for any child, and very supportive.</li> <li>Recent ophthalmic screening practice update very beneficial. Standardised screening encompassed into a holistic child health programme (School Health Implementation Project “SHIP”) for Junior Infants, fifth class, and new entrants. Average waiting time 3 months excellent linkages between School Nurse and Ophthalmology service. Written feedback and verbal queries addressed quickly and effectively. School nurse recognised by School staff and</li> </ul>

	<p>PHNs as link for parents of children at primary school if concerns re their child's vision. Excellent uptake in the screening programme.</p> <ul style="list-style-type: none"> <li>Sligo - Implementation of vision screening standard positive, and referral pathways very clear.</li> </ul>
<b>3</b>	<p><b>What issues/concerns exist in relation to PHN Preschool Vision Screening?</b></p> <ul style="list-style-type: none"> <li>Galway – Waiting list for diagnosis and treatment.</li> <li>Longford Westmeath – Lack of PHNs to carry out all core visits within timeframe/lack of 2<sup>nd</sup> level services/very long waiting lists currently.</li> <li>South Tipperary – PAC training delivery is reliant on an already over burdened Consultant Ophthalmologist who is working without an Orthoptist. (In keeping with other under delivered or undelivered PAC updates and SNA in particular circumstance. Having an assistant would be of benefit e.g. with Sonksen Silver. In some cases schools assist by supplying an SNA in particular circumstance.</li> <li>Dublin South West – No referral pathway. Parents advised to see GP for Ophthalmology referral.</li> <li>Laois Offaly - Waiting List for Ophthalmologists and Optometrists.</li> <li>Cork North Lee - Treatment not available due to resources, at least 1yr waiting list. Opportunity lost for prevention of sight loss.</li> <li>Donegal - Screening for visual acuity and colour blindness not carried out. PHNs not provided with clinical outcome of referrals to Ophthalmic Clinic. Notice of DNAs at Ophthalmic clinic sent to PHNs for follow up or re referral –Time consuming and inappropriate practice.</li> <li>Sligo – Local child health training and development officer reassigned to other project, with impact on training, upskilling, evidenced based practice and auditing.</li> <li>Long waiting lists for referrals to Orthoptist at SRH.</li> <li>Some referrals can be deemed inappropriate –e.g. parental concern, sibling in treatment, contrary to the referral criteria in use.</li> </ul>
<b>4</b>	<p><b>What issues/concerns exist in relation to PHN School Vision Screening?</b></p> <ul style="list-style-type: none"> <li>Galway - Waiting lists for children are referred to ophthalmic services. Children discharged from eye clinics in primary school and wearing glasses with follow up reliant on parents. Increased workload for rescreening these children for entry into ophthalmic services again. Concerns if 6<sup>th</sup> class referrals will receive a service.</li> <li>Clare – Inadequate clerical support. Some children can fall through net and present at 6<sup>th</sup> class without having had junior Infants vision screening. Lack of appropriate school facilities can impact on school screening. Lack of understanding by some teachers of the importance of this screening.</li> <li>Longford Westmeath – One unfilled school PHN post/lack of national clarity on best practice for screening and target classes.</li> <li>South Tipperary – Referrals added to long waiting (&gt;2yrs) linked with unfilled Orthoptist post.</li> <li>Dublin South West – No referral pathway, parents advised to attend GP for Ophthalmology referral, no feedback, and parent is responsible for follow up.</li> <li>Laois Offaly - Waiting list for Ophthalmologists and Optometrists.</li> <li>Cork North Lee - Treatment not available due to resources, at least 1yr waiting list. Opportunity lost for prevention of sight loss.</li> <li>Roscommon – Long waiting lists for referral to Ophthalmology,</li> <li>Donegal - The combined role of the clinic PHN with school screening and immunisations precludes the CPHN from undertaking vision screening in September and March., the earlier in The school year the child is screened the better the overall outcome with treatment particularly in relation to squints. DNA policy required. Concerns for children who have purchased glasses privately. Concerns for homeschooled children who may not receive a screening service. 2005 Pac training manual needs to be updated. Parents need awareness of school screening service.</li> </ul>



	<ul style="list-style-type: none"> <li>Sligo - Long waiting lists for those referred to Orthoptist. Local child health training and development officer reassigned to other project, with impact on training, upskilling, evidenced based practice and auditing.</li> </ul>
<b>5</b>	<b>What are your views on the long term role for PHNs in Pre School Vision Screening</b>
	<ul style="list-style-type: none"> <li>Galway – Essential service for early dedication, referral and treatment of vision problems. BHFC review and national guideline required. Ongoing audit of service required.</li> <li>Longford Westmeath – It is a very important role for PHN.</li> <li>South Tipperary – Part of holistic and comprehensive core developmental check requires regular opportunity to update PAC training.</li> <li>Dublin South West - Referral pathway to community Orthoptist. Require follow up on children identified as having a vision problem. Require ongoing education/training and audit of service.</li> <li>Laois Offaly - Appropriate training, clear pathways and national guidelines required.</li> <li>Cork North Lee - PHN has vital role in early detection, treatment and prevention of sight loss</li> <li>Donegal – Current role and direct referral to ophthalmic clinics should continue.</li> <li>Sligo – A more collaborative approach with ophthalmic/Orthoptic Services to ensure PHNs are competent in the best practice standards for care, assessment and referrals.</li> </ul>
<b>6</b>	<b>What are your views on the long term role for School PHNs in School Vision Screening?</b>
	<ul style="list-style-type: none"> <li>Galway – Essential service for early dedication, referral and treatment of vision problems. BHFC review and national guideline required. Ongoing audit of service required. Valuable service for primary schools going children. Concerns for children with special needs and difficulty using LogMAR. Appropriate screening tool for these children.</li> <li>Longford Westmeath – Dedicated school PHN posts are critical. Strong evidence to continue vision screening.</li> <li>South Tipperary – Essential service. I concur with below.</li> <li>Dublin South West - PHNs need ongoing professional education on vision screening. Referral pathway required ideally with the local hospital based Orthoptist. Treatment must start before the child is 7 years old with feedback to PHN who is screened and referred.</li> <li>Laois Offaly – Appropriate training, clear pathways and national guidelines required.</li> <li>Cork North Lee - PHN has vital role in early detection, treatment and prevention of sight loss.</li> <li>Donegal - Vision Screening of Junior Infants is invaluable and may have long term impact on the children's physical, emotional and educational wellbeing. Benefits of screening 5<sup>th</sup> class are questionable.</li> <li>Sligo – A more collaborative approach with ophthalmic/Orthoptic Services to ensure PHNs are competent in the best practice standards for care, assessment and referrals.</li> </ul>
<b>7</b>	<b>What are the views of School PHNs in relation to their long term role in School PHN vision Screening?</b>
	<ul style="list-style-type: none"> <li>Galway – Dedicated School PHN posts essential for screening of junior infants to ensure early dedication, treatment and intervention. Query value of 6<sup>th</sup> class screening if unable to provide a follow up service. Colour vision screening should continue. Concerns for children screened and remaining on waiting list.</li> <li>Clare – Dedicated School PHN role is pivotal in promoting high uptake rates of school vision screening. Would welcome the continuation of 6<sup>th</sup> class, particularly as there are requests from parents to request screening.</li> <li>Longford Westmeath – Dedicated school PHN posts are critical. Strong evidence base to continue vision screening.</li> <li>South Tipperary– Children need to be screened in junior infants – lazy eyes in particular need to be treated age of 7yrs.</li> <li>Dublin South West - PHNs are ideally placed to screen children's vision in school. Need clear referral pathways.</li> </ul>



	<ul style="list-style-type: none"> <li>• Laois Offaly- Essential service in early detection of vision problems, as if undetected will impact social and educational achievement.</li> <li>• Roscommon - Essential service in a familiar location by an experienced schools public health nurse which promotes performance of test other medical/psychological emotional//communication needs of the child may be identified and require. Ensures a holistic view of the and not just task orientated approach. Provides opportunity for children who moved into area who could have missed preschool service. Liaison with school/parents re compliance of wearing of glasses or new prescription required. Provides opportunity for follow up for families with Child Protection concerns if appointments are not attended. Colour Vision testing is performed and letter issued to parents for school /career choices.</li> <li>• Donegal - Provide a very valuable evidence based service. Benefits of early detection and treatment of visual defects is well documented and leads to an enhanced school educational experience. Target audience leading to a good uptake. Home school children require follow up. National DNA Policy required.</li> <li>• Sligo – Recommend School nurses to meet with Ophthalmologist and orthoptist on an annual basis to ensure practice is up to date and discuss concerns/issues.</li> </ul>
8	Any other comments:
	<ul style="list-style-type: none"> <li>• Galway – Dedicated School PHNs best placed for vision screening in primary schools. Training, education and audit required in line with national guidelines. School PHNs have indicated that more parents are seeking HSE services over the past number of years as opposed to availing of other services. Referral pathways required for colour vision. Concerns for children on waiting lists for diagnosis and treatment with impact on social and educational needs.</li> <li>• Clare – There should be an awareness programme for parents and teachers to highlight the importance of the vision screening service and the importance of children adhering to the treatment i.e. wearing the patch and glasses as recommended. Feedback from Ophthalmology clinic attendance on outcome of visit should be available to referrer.</li> <li>• Longford Westmeath – A quality service needs to be resourced, supported by national policy and strong governance structures.</li> <li>• South Tipperary – 6<sup>th</sup> class children may no longer be seen by ophthalmologist and instead are contracted out to Opticians privately. Once children leave primary school and if they are not under medical there are not entitled to service.</li> <li>• Dublin South West - The screening PHN would benefit from having the Child Health Record for reference. The Child Health record could then be archived after school screening. Need standardised IT Database for service &amp; capacity planning, tracking of DNAs, Referrals etc and for data analysis. Need dedicated admin support for this system.</li> <li>• Laois Offaly - National Guidelines and standard Screening tools should be rolled out nationally with the appropriate education to ensure equity of Service.</li> <li>• Cork North Lee - PHN's are in a position to detect, support, and review all children. Vital role both in School and Area PHN. If treatment is available and the Ophthalmic Physician is available can prevent sight loss. School PHNs screen in junior infants and check in senior infants all those referred. If there was no waiting list it would prevent the need for re-screening and ultimately prevention of sight loss. Need for review by ophthalmic physician has to be escalated from soon to urgent.</li> <li>• Roscommon - Ophthalmologist/Orthoptist willing to engage with PHNs for delivery of education updates.</li> <li>• Donegal - Ophthalmic Service should be making referrals directly to TUSLA for repeat DNAs. Glasses frames being provided through HSE Services acceptable to children. If early screening is preferable and dual role of CPHN in screening and immunisation precludes vision screening early in the school year then the possibility of screening in the crèche preschool year might be considered. Regular practice update for area PHNs would be useful.</li> </ul>

## *Appendix 10: Summary & Full Submission from the Irish Medical Organisation (IMO)*

### *Summary Submission from the Irish Medical Organisation (IMO)*

It is Government policy that the majority of an individual's health and social care needs be met in community or primary care settings; this includes individuals who require medical eye care. It is the position of the Irish Medical Organisation (IMO) that such medical eye care should be delivered, to the greatest extent possible, by ophthalmologists; thus ensuring that patients seen in the primary care environment can avail of services to the same specialist standard as that which is available in the hospital setting.

At present, specialist medical eye care is delivered in primary care settings either by HSE employed community ophthalmic physicians or via contracted providers through either the COSS or the COSMTS.

The IMO contends that there are too few community ophthalmic physicians in the system at present, and those who are in the system are bedevilled by inconsistent referrals leading to long waiting lists. The provision of support staff and necessary equipment is also a problem for this group of doctors, who, it must be remembered, are independent medical specialists. The IMO would strongly argue that the current deficits, both in terms of community ophthalmic physician numbers and the supports available to them must be addressed.

The COSS allows contracted ophthalmologists to provide biannual eye tests to medical card holders and to facilitate the provision of the necessary spectacles and appliances. The COSS was felt to be overly cumbersome and, as a result, the COSMTS was launched on a pilot basis. The COSMTS allows contracted doctors to provide enhanced medical treatment to medical card holders. Despite Ministerial approval for its expansion, the COSMTS has never been 'rolled out' beyond the pilot practices. The IMO believes strongly that this roll out is long overdue, and should be prioritised by the HSE.

Recent reports from the National Treatment Purchase Fund (NTPF) highlight the unacceptably long waiting lists for specialist eye care in hard pressed hospital settings. Tackling these waiting lists requires a full service response. However, patients requiring eye care, whose needs can be met in the primary care setting, deserves to be treated to the same specialist standard as they would expect to receive in the hospital setting. This, the IMO believes, requires that the ophthalmologist be at the centre of primary care eye services going forward.

Legislatively, ophthalmologists are the only community based eye care specialists who are entitled to make medical diagnoses and to practice independently. Patients can reasonably expect to be treated by recognised specialists, and this should be the case wherever and when ever possible. The IMO would caution against allowing 'light touch regulation' of eye care without first seriously considering the consequences.

In the view of the IMO, both directly provided and contracted community based ophthalmologist services provide the State with an excellent value proposition, and we would encourage investment into those services now to realise the benefits later.

The Irish Medical Organisation (IMO) was invited to engage with the Review in early September 2014, with a subsequent invitation to make a submission to Review personnel in December 2014.

### **Current Community Based Services**

It is Government policy that ninety to ninety five percent of an individual's health and social care needs be met in a community or primary care settings. The ongoing difficulties in the public finances, and difficulties in addressing hospital outpatient waiting lists, make this policy aim not just desirable but essential. Accordingly, there is a need to ensure that the State maintains and supports a specialist eye doctor service in community and primary care settings.<sup>47</sup>

The medical treatment of the eye is known as Ophthalmology. It has been recognised that there are two branches of ophthalmology, the surgical and the medical. The majority of traditional surgical ophthalmology takes place in hospitals, and is under the care and supervision of Consultant Surgeon Ophthalmologists. However, as recognised in the National Eye Care Plan, the majority of medical eye treatment can be delivered in community, or primary care, settings and it is there that this submission will focus.

Medical eye care and treatment is delivered by Ophthalmologists; these doctors are entered on the Specialist Register by the Irish Medical Council and are may practice independently, may be consulted by their colleagues, and will assume full and continuing clinical responsibility for those aspects of patient care on which they have been consulted. In this level of expertise and specialism, they are unique in the delivery of non-hospital eye care. As independent specialist practitioners, Ophthalmologists are the only professionals working in non-hospital eye care that may, under current legislation, make medical diagnoses of and prescribe treatments of medical eye conditions.

Accordingly, the IMO would contend that a community, or primary care based eye service must be specialist led and practice evidence based medicine of the highest standard. To do otherwise would not be in the best interests of patients, and may result, despite the best of intentions, in flawed diagnoses which require later specialist intervention.

In terms of actual service delivery, ophthalmologists provide services to patients on behalf of the State either as direct employees of the HSE, or as contractors for service. The submission will now briefly examine these roles and their responsibilities.

### **Community Ophthalmic Physicians**

Community Ophthalmic Physicians (COPs) are HSE employees and they are charged, primarily, with providing medical eye care to a range of identified groups comprehended within screening programmes; school based screening programmes being the most widely known. Among the conditions presenting for treatment by COPs are strabismus, amblyopia, refractive errors and congenital eye disease. The COP service receives referrals from nurses, optometrists, other eye care professionals and, of course, General Practitioners. However, it has been observed that "[I]n many cases the health care professionals carrying out this range of vision screening checks are inadequately trained to identify vision problems." This leads to the appearance of high false positive rates and "consequently very long waiting lists for specialist review in the local health clinics." These waiting lists can, in some cases, run as long as four years.

There can be no doubt that these waiting lists are too long, especially if one is dealing with a referred child and an anxious parent. This is exacerbated by the fact that the specialist care

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<sup>47</sup> For a discussion of waiting lists for eye care services in Ireland, see 'National Eye Care Plan' Health Service Executive, National Clinical Programme in Eye Care, pp 9 - 10

that is delivered is often provided in “poorly resourced clinics with inadequate diagnostic equipment.”<sup>48</sup>

Nonetheless, despite the small number of COPs in the health service, the long waiting lists, and the less than optimal working conditions, the COP service is the only specialist and diagnostic community based eye service delivered by HSE employees.

### **Contracted Ophthalmological Services**

In recognition of the constraints placed on both hospital based ophthalmology services and the COP service, the State has contracted for ophthalmological services with ophthalmologists who are not State employees. This is done via the Community Ophthalmic Services Scheme (COSS) and, latterly, the Community Ophthalmic Services Medical Treatment Scheme (COSMTS).

The first of these, the COSS, is delivered by approximately twenty private practices and provides medical card holders with a biennial eye test, and facilitates the provision of the necessary spectacles and appliances, as required. It was felt that this Scheme was, by its nature, cumbersome, and insufficiently clinical to enable participating eye doctors to respond adequately to acute conditions once detected. As a result, in 2004, the COSMTS was launched as a pilot scheme taking in four contractors providing diagnosis and treatment in six practice sites. Unlike the COSS, Ophthalmologists participating in the Medical Treatment Scheme could accept referrals from General Practitioners and Optometrists (for example) and diagnose and treat acute conditions. The Medical Treatment Scheme was rolled out on a ‘pilot’ basis only and despite Ministerial approval to make it more widely available, no further roll out has occurred.

### **The Rationale for a Specialist Eye Care Service in the Community**

As observed in the National Eye Care Plan

“Increasing patient numbers and the growing incidence of chronic diseases are placing an enormous strain on the current model of eye care. Hospital centres are overburdened by chronic diseases, most of which could be appropriately diagnosed, treated and managed in the community by eye doctors in a decentralised model.”<sup>49</sup>

To ease the burden on overstretched hospital based eye care will require a careful and gradual re-balancing of eye care services and delivery in Ireland. As greater amounts of this type of care are delivered in community settings, so the balance of funding can be brought into a new alignment. In order for a specialist community based eye doctor service to assume its full share of the patient workload, it must attain sufficient scope and scale itself. Notwithstanding the necessary up-skilling of other professionals working in this field, in order to ensure community based eye care makes a significant difference in terms of keeping patients from having to attend hospital, it must be specialist led, and to the greatest extent possible, specialist delivered.

As referenced above, the community based Ophthalmologist, whether a HSE employee or a contractor for service, is the only professional in that setting who can assume complete and continuous responsibility for their patients care. To ensure that the migration of eye care services from hospitals to the community is not to be

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<sup>48</sup> There are twenty two Whole Time Equivalent (WTE) Community Ophthalmic Physicians employed by the HSE. ‘National Eye Care Plan’ (pp. 12 - 14)

<sup>49</sup> National Eye Care Plan (p.21)

accompanied by any diminution in service, the IMO would submit that the Ophthalmologist must be at the centre of the delivery of care and have a continuing relationship with the patients under their care.

### **Enabling Specialist Eye Care in the Community**

It has been noted above, that a feature of the COP service is long waiting lists, brought about, in large part, by inappropriate referrals. To offset this situation, a refined screening service is required. This would include fully trained nurses and orthoptists working with an enhanced COP cohort to ensure that only those patients who need specialist care, receive that care. Shorn of the need to act as their own screening service, COPs could, increasingly focus on chronic care, particularly in respect of adults who may otherwise end up on hospital waiting lists. This is a double financial benefit for the State, in terms of keeping patients off waiting lists and out of hospitals, but also in terms of deriving the full benefit of the specialist skills of the COPs.

The dictates of the Moratorium on Recruitment have hit the COP workforce hard; each loss and subsequent non replacement of a doctor is keenly felt in such a small group. The IMO contends that increasing COP manpower is a key step in ensuring that specialist eye care in the community attains critical mass. It has been mooted that the COP service be clustered into a small number of centres per hospital region. In terms of the need for COP clinics to function as effectively as possible in terms of support teams and infrastructure, there may be some merit to this suggestion.

### **The Expansion of the Community Ophthalmic Services Medical Treatment Scheme**

It has been noted in the National Eye Care Plan that the COSMTS “is an enhanced medical version of Community Ophthalmic Services Scheme (COSS) for medical card holders requiring medical diagnostic and treatment services provided by eye doctors.” As noted above, Ministerial approval to extend the Medical Treatment Scheme beyond the ‘pilot’ practices was given in 2007. With the severe deterioration in the public finances since 2008, this project has, unfortunately, been stalled for some years now. This is despite the best efforts of the IMO and of the participating Ophthalmologists to have the Scheme extended.

<sup>50</sup>

However, in the context of re-appraising non-hospital eye care services, the case for the expansion of the Medical Treatment Scheme is worth re-stating. In the first instance, the Medical Treatment Scheme provides value for money; using the most recent figures available, the IMO has calculated that the average cost to the State per specialist consultation was €80, which is between sixty and one hundred percent less than a consultation in the hospital sector.

To better understand the effectiveness of the Medical Treatment Scheme it is worth assessing the results of audits recently conducted by practices that participate in the Scheme. In one instance, one practice, with surgeries in Ranelagh (Dublin) and Naas (Kildare), took one hundred and sixty two referrals from the eye care waiting list in Adelaide Meath National Children’s Hospital (AMNCH). Of those, only fifteen (nine percent of the total) were subsequently referred back to AMNCH. The vast majority were treated in community settings, either in the Medical Treatment Scheme practices, or referred to other community based service providers. Similarly, another audit took five hundred patients from the waiting list at Cork University Hospital (CUH), the vast majority of whom were treated

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<sup>50</sup> National Eye Care Plan (p.27)

just as effectively in community settings without the need for them to endure long waiting lists with the attendant strains and stresses, and at lower cost to the State.

In one final instance, Our Lady's Children's Hospital Crumlin referred a group of patients to a Medical Treatment Scheme practice in Bray (Wicklow) and Fairview (Dublin) in late November 2013; it was requested that the patients, all of whom were under sixteen years of age, should be seen before the end of 2013. This group consisted of eighty three referrals of which sixty accepted appointments and were examined by two paediatric ophthalmologists over a four week period. Over half of these children were discharged by the practice with the remainder referred for appropriate follow up. (Appendix A).

While the long held view of the IMO is that the Medical Treatment Scheme ought to be expanded, it is accepted that there are qualifying criteria in terms of the need for the participating doctor to demonstrate that they are available on a full time commitment, have sufficient IT and other facilities and have the requisite indemnity and insurance. However, as most, if not all, of these costs must be met by the participating eye doctor, these should not work against the gradual roll out of the Medical Treatment Scheme. Indeed, the IMO is aware of four eye doctors who could join the Medical Treatment Scheme within a short time frame. Furthermore, it should be borne in mind that as practices join the Medical Treatment Scheme, they would depart the COSS, which would yield a saving to State. (Appendix B).

Two further points are worth making in this regard. Firstly, as knowledge of the Medical Treatment Scheme increases, in line with its expansion, it can reasonably be expected that participating practices will be required to hire additional staff, including specialist eye doctors. Secondly, the Scheme is funded through the Primary Care Reimbursement Service (PCRS) of the HSE. This funding arrangement has worked well since its inception and would allow for the Medical Treatment Scheme to be easily adaptable to a 'Money Follows the Patient' funding model.

## **Conclusion**

The IMO is grateful for the opportunity afforded to us to set out the benefits of a specialist community based eye doctor service. We believe that there is a compelling logic in ensuring that patients can avail of a specialist service as close to their home as possible without the automatic need to attend a hospital. When considered from the point of view of a patient, it is preferable to have an ongoing relationship with "their" eye doctor as opposed to having to attend, unfortunately impersonal, hospital outpatient departments.

However, while community based care is very often preferable to hospital care, it must still be considered to be, and valued as, specialist care. Under the current legislation, Ophthalmologists are the only eye care professionals who are entitled to make medical diagnoses and practice independently. Patients can reasonably expect to be treated by recognised specialists and this should be the case, whenever possible. We would caution against allowing 'light touch regulation' of eye care without first seriously considering the potential consequences.

In the view of the IMO, both aspects of community based Ophthalmology, whether delivered by HSE employees, or contracted specialists, need to be enhanced and while the two may be complimentary, they are not in conflict. Both services offer the taxpayer an excellent value proposition and, while we acknowledge the scarcity of resources, we would urge that we invest now to reap the benefits later.

## Appendix A to IMO Submission

Tallaght OPD Referrals 2013-2014		Ranelagh/ Naas
Total no of referrals		162
Total number discharged/removed from Tallaght OPD:		147
* Total DNA	44 (27% )	91%
3 consecutive appointments given to patients in Ranelagh/Naas offering appointments but failed to attend		
Total patients seen		112
Discharged from Tallaght		147
Followed up in the Community under COSS or GP/Optician as required		
RVEEH Cataract Referrals:		20 = 13%
Referred back to Tallaght		15 = 9%
(Reason for Referral Back as below)		
*Orthoptic	5	
*YAG	1	
*Dermatology	1	
*OPD	4	
*Diabetic	2	
*Other:	2	
6 Referrals did not Attend for Other Reasons:		
2 seen in the RVEEH		
1 no need for apt.		
1 to stay with Tallaght , has MND		
2 Passed away.		



### CUH Waiting List Initiative Final Figures (2014)

<u>Total Number of Patients Seen:</u> <u>(by Dr Travnor, not Dr Mark James</u> <u>or Dr Ann Collins)</u>	501
<u>Total Appointments Scheduled:</u> <u>(For Dr Travnor)</u>	574 (+8 for patients who previously DNA'd)
<u>Total DNA's:</u>	76 (+5 of those given second appointment) (13% of total scheduled appointments)
<u>Total Discharged:</u>	394 (78% of total number seen)
<u>Total Referred for Cataract Surgery:</u> <u>(1 or 2 cataracts)</u>	87 (17% of total number seen)
<u>Total Referred for CUH Follow Up:</u>	20 (5% of total number seen)
<u>Total Needing OCT Scan of Macula/Disc:</u>	37 (7% of total number seen)
<u>Total Needing Visual Field Testing:</u>	34 (6% of total number seen)



## *Appendix B to IMO Submission*

### Questionnaire for inclusion in the: **Community Ophthalmic Services Medical Treatment Scheme (COSMTS)**

1. Can you please confirm that you are an active participant in the current community ophthalmic services scheme (COSS)?
2. How many sessions per week do you spend in your own practice premises? - A session is a morning, afternoon or evening clinic.
3. Do you hold a part-time hospital or COP post, if so what is your session of commitment?
4. Do you practice ophthalmology exclusively? If not, please state your other specialty commitments.
5. Please state the location or locations at which you see COSS patients.
6. Please state which of the following management facilities you have available in your practice premises:
  - a). Administrative support staff such as secretary/receptionist
  - b). A recognised electronic patient record system (EPR)
7. Please list the practice equipment at each of your practice locations on a separate sheet.
8. Do you have professional indemnity insurance?
  - a). Does this indemnification cover you in each of your practice premises?
9. Do you have public liability insurance cover at each of your practice premises?
10. Do you have employers' liability insurance cover at each of your practice premises?

### *Appendix 11: Submission from the Irish College of General Practitioners*

The Irish College of General Practitioners (ICGP) welcomes the opportunity to make a submission to the HSE Primary Care Eye Services Review Group.

The main issue that the ICGP would like to see addressed is the geographical variability of access for patients to community and hospital based ophthalmology services. In some parts of the country all patients have access to HSE employed community ophthalmic physicians. In other areas the COSS accepts referrals covering medical card patients only and children referred by the school medical or public health clinic. There appears to be variability in access to COSS depending on geographical area. The COSMTS which is located in six sites nationwide (an enhanced version of the COSS) only accepts patients with medical cards. Patients with private health insurance access private ophthalmic physicians. This leaves the vulnerable group with neither medical card nor insurance unable to access community based services. If this group of patients have an acute eye problem they can attend the emergency department in their nearest regional hospital with an ophthalmic department. On the other hand if they have a chronic problem then they have to be referred to the secondary hospital out-patient services. The waiting list for access to outpatient services for all patients is very variable and can be up to two years in both community and secondary care services. Timely access to service leads to earlier detection and treatment of eye disease and prevention of sight loss. Elderly people are particularly vulnerable in this regard as reversible loss of vision untreated can lead to loss of independent living.

The school vision screening programme identifies children with refractive errors but the follow up of these children with access to private eye examination/prescription is also inconsistent. This can have serious implications for their ability to engage successfully in education.

The ICGP would like to see access to ophthalmic services based on patient need rather than on ability to pay particularly in the case of patients with no medical cover. It is essential that the GP is informed when patients are seen by community and/or secondary care services to ensure continuity of their overall care. The review group intend to address electronic communication between GP sites and community/hospital services which is welcome. It would also be helpful to address all aspects of communication from hospitals to general practice as this is very variable throughout the country and if addressed would enhance quality and safety of patient care.

Enhancement of community based ophthalmic services would enable improved access for patients in a cost effective manner.

The ICGP welcomes the Primary Care Eye Services Review and would like the opportunity to provide further feedback to the process in due course when the report from the group is available for comment.

## *Appendix 12: Summary & Full Submission from the National Coalition for Vision Health*

### *Summary Submission from the National Coalition for Vision Health*

Visual impairment and blindness will increase by over 21% over the next 10 years. The Irish population is increasing and the number of people over the age of 65 is set to increase by 14%. Consequently, the number of people affected by vision threatening eye conditions will increase as many of these conditions are directly related to age.

Vision loss has many social implications aside from loss of the ability to see, vision loss is associated with an increased risk of falls, depression, hip fractures and earlier admission to nursing homes. This cohort is also twice as likely to use health care services.

In response to this growing crisis in Irish healthcare, the National Vision Coalition was formed, subsequently launching the document 'Development of a Framework to Adopt a Strategic Approach for Vision Health in Ireland'. This document called on the need to address the issues for increasing needs in vision care faced by current and future generations of Irish citizens. There are 8 principles around which any future vision strategy should be designed:

- Any future strategy should be all-encompassing and include eye health problems for both children and adults.
- Quality and safety need to be maximised for anyone accessing services.
- Services should be person-centred.
- Patients should have choice and control and the ability to live fulfilled lives.
- Seamless service pathways should be put in place.
- Evidence-based approaches and equality of access should be prioritised.
- Research should also be prioritised.
- The strategic development of eye health should be aligned with the wider public health policy framework.

The current key challenges for vision care in Ireland relate to suboptimal levels of connectivity and integration:

- Communications between professionals are essential for an efficient and high quality service.
- Currently no referral pathways between primary, secondary and tertiary care.
- Referral pathway depends on geography and local "pathway".
- Difficulties in getting feedback on those referred into system.
- No referral refinement; need to reduce patients going into system unnecessarily.
- No follow-up care mechanisms for stable treated patients; need to get patients out to open places to get patients in for treatment.

In order to address these challenges a clinical care pathway programme needs to be established which is centred on the service users. To ensure care is provided for all immediate aspects of eye care, the programme should include pathways for the following;

- Paediatric Eye care
- AMD
- Cataract
- Glaucoma
- Diabetic Retinopathy
- Acute Red Eye

This will ensure that the primary causes of visual problems in the population are addressed.

International best practice demonstrates that good health care starts at primary care level. Any vision strategy must be underpinned by a comprehensive primary care programme.

- Increased capacity in eye services for acute delivery of care; appropriate care for those who need it.
- Reduced waiting lists; timely access.
- Enhance community based case services.
- Increase efficiency and cost-effective use of secondary care resources.
- Improve patient access, experience and outcome.

The key national objectives for a vision strategy therefore must be;

- The co-ordination and integration of services; services need to be linked and accessed in an equally and timely manner.
- The focus on prevention and intervention of sight loss.
- Knowledge and awareness; national patient education programmes into responsibility, taking care, and risk awareness.
- Research; Important role in the promotion of healthy vision, combating eye disease and eliminating avoidable sight loss and ultimately an improvement in the quality of care for the service users.
- Inclusion; all service users need to be included.

These objectives can be achieved by the adoption and use of key enablers;

- Development of protocols and guidelines by professional stakeholders working in partnership through the different levels of the healthcare pathway.
- Adoption of international best practices.
- Investment in IT; a robust IT infrastructure is essential in implementing seamless care pathways.
- Use of multidisciplinary teams working within support networks will ensure appropriate and timely care is delivered to service users.
- Up-skilling and training of key professionals; optimising healthcare provision throughout the pathway thus facilitating appropriate care at the appropriate level of care.
- Current resource allocation reviewed and re-directed to ensure resources are going where they are most needed.

### **Appendix 13: Submission from ChildVision**

ChildVision is a national education service for children who are blind or visually impaired. It caters for children from birth to 22 years of age and provides a holistic approach to these families.

ChildVision provides a multidisciplinary assessment service which is focused on a child's vision and the impact visual loss has on their education, participation within the family and their community. This assessment is conducted by a vision therapist, nursing staff, occupational therapist, physiotherapist, speech and language therapist, mobility specialist and a technical skills specialist.

Following an assessment a child may attend the early intervention service, preschool, special primary school, secondary school or vocational training. These services are supported by a range of different services including music therapy, horticulture, equine assisted therapy, pottery, residential services and swimming.

Vision stimulation is the main focus of the work in ChildVision and to support this we operate an Ophthalmology clinic in association with the University Children's Hospital Temple Street and a low vision clinic. We also have a visiting ocularist on site.

In relation to primary eye care services we have come across a number of concerns:

#### ***Difficulties with Transition of Children to Adult Services***

Once a child reaches 16yrs of age in the hospitals their care is moved to the adult hospitals. In paediatric care generally children are being reviewed every 6m-1yr. It seems to take up to 2yrs for this transfer of services. In the meantime if a child runs into "trouble" the paediatric services will review them, but it seems like a long time for transition. Also in adult services these individuals are not reviewed as often which parents find difficult. We would have experienced young adults with a visual impairment such as optic nerve hypoplasia not having an ophthalmology review in 2 yrs.

#### ***Delays in Processing Applications for Aids and Appliances***

Parents have spoken in particular around photo chromatic lenses and needing excessive paperwork to support application. Where we have most difficulty is accessing aids and appliances to support communication needs such as Assistive communication.

#### ***Ophthalmology Care Based in Acute Hospitals***

In ChildVision a number of the children would have additional needs. These children have spent many days in hospital and have difficulty re visiting hospital settings for an eye examination. The current ophthalmology clinics are not suited to their needs with long waiting times in waiting rooms, noisy and distracting environments when vision assessments are being carried out.

#### ***Ophthalmology Reports***

In order for a child to access the services of ChildVision they require a vision report from a referring ophthalmologist. Parents are having increasing difficulty seeking this information due to the lack of clerical staff in acute settings. This delay can lead to a delay in assessment and intervention.

#### *Appendix 14: Summary Submission from the Irish Guide Dogs for the Blind (IGDB)*

Irish Guide Dogs for the Blind (IGDB) is a national charity established in 1976 with a world class dog training and client training facility in Cork. IGDB employs over 70 staff and work with a nationwide network of volunteers who help raise the dogs and the funds to support the organisation. Annual running costs are approximately €4.8M; IGDB receives €840k from statutory sources (€780K from the HSE). They raise the remainder from fundraising and voluntary donations; in the current climate this is proving increasingly difficult.

In 2014, IGDB trained 239 clients and supported many hundreds more with aftercare and practical interventions. All services and supports are offered free of charge. Their current waiting list as of June 2015 is set out below:

<b>Breakdown of waiting List by service</b>	
Guide Dog	60
O&M - Long Cane Applicant	29
ILS - Home Skills Applicant	74
ILS - The Next Step Applicant	12
ILS - Leisure Applicant	75
ILS - Gardening Applicant	48
<b>Total</b>	<b>298</b>

*Figure 5.3      Waiting List for IGDB Services as of June 2015*

There are over 13,000 people registered blind in Ireland; this is set to increase to 15,000 by 2020 as the overall population ages. Many persons who are eligible to be registered blind are not currently registered.

CSO projections estimate that the number of people aged 65 and over will almost double in the period 2006 to 2026. Data supports a marked increase in the frequency of blindness and vision impairment with advancing age e.g. 1 in 5 people in the UK aged 75 and over are living with sight loss.

Over a third of older persons with vision loss never go out independently in their local area. Over a quarter of younger persons never go out in their local area, without assistance from a sighted person. Mobility Training with a Guide Dog or with a Long Cane enables a person to better participate in society through work study and leisure with the obvious positive impact on their mental, physical and financial wellbeing.

IGDB is committed to meeting the increased demand through providing equitable access to efficient and high quality services and supports. They continue to invest in staff and structures in order to build capacity. An over dependency on fundraising income in a difficult economy mitigates against medium to long term planning and a sustainable business model. Peer organisations are funded up to 90% of operating costs. IGDB urgently requires an increase of €500K in their multi-annual funding from the HSE and a commitment to a comprehensive review of funding for what are life changing services.

## *Appendix 15: Submission from the Department of Health Disability Unit*

### **Assistive Technology/Aids and Appliances for Blind People**

Funding for assistive technology/aids and appliances for blind people is generally provided from the Aids and Appliances budget and not through the Disability Programme, although some areas have derived their own mechanism for funding items not available on the medical card for items of assistive technology through a Communications budget held by the Disability Manager.

In Community Healthcare Organisation (CHO) 9, funding is provided to NCBI for assistive technology – an amount is set aside each year from the aids and appliance budget and the amount depends on the budget available each year.

### **Services for blind and vision impaired**

Persons with Disabilities, including blind and vision impaired can access the broad range of Acute, Primary and Community based services as well as specialist disability services, which are provided in a variety of community and residential settings in partnership with service users, their families and carers and a range of statutory, non-statutory voluntary and community groups.

Services for blind and vision impaired are provided as part of Physical and Sensory disability services and are delivered directly and in partnership with a number of voluntary service providers, including NCBI, the Irish Guide Dogs for the Blind and the National Association of Housing for the Visually Impaired.

### **National Council for the Blind of Ireland (NCBI)**

NCBI is a not for profit charitable organisation which provides support and services nationwide to people experiencing sight loss. The overall aim of NCBI services is to enable people to live an independent life of their choice.

NCBI provides services to over 7,000 people every year. Almost 95% of these people have some degree of useful vision while less than 5% are blind.

NCBI offers community based services to help people to adapt to sight loss and maintain their independence. These services include emotional support to the individual experiencing loss of vision and to their families, advice and information on all aspects of vision loss as well as practical support and solutions to the challenges encountered by people with vision loss. Services are offered to people of all ages, from birth through to older age.

NCBI also provide a range of services to public and private organisations to make sure that their services are accessible to people who are blind and vision impaired.

NCBI advises government departments, companies and individuals on how to make the built environment and services accessible to people with sight loss.

### **Funding**

HSE Disability Services fund NCBI, under Section 39 of the Health Act and subject to Service Arrangements, in the amount of €6.7 million in 2014 to provide a range of centre, domiciliary and community based services to people who are blind or vision impaired. As the Head Office for NCBI is Drumcondra, CHO Area 9 holds the core budget for this organisation, which includes

the national management and administration functions that support the national delivery of services by NCBI.



## *Appendix 16: Submission from CORU*

The Opticians Board is the current regulatory body for Optometrists and Dispensing Opticians, until such time as the registers are transferred to the Optical Registration Board at CORU. In relation to regulation and the principles of good regulation, these include:

- Proportionality - Only intervenes when necessary, provides appropriate remedies to risks posed and costs are identified and minimised.
- Accountability - Can justify decisions, is consistent, and applies rules & standards fairly.
- Transparency - Is open, simple and user friendly.
- Targeting – Is focused on the problem, minimises side effects.

CORU is one of the regulators of health and social care professionals along with the Medical Council, the Nursing and Midwifery Board, the Dental Council and Pharmaceutical Society. CORU was established in 2007, and is a multi-profession regulator. The purpose of CORU is to protect the public by promoting high standards of professional conduct and professional education, training and competence among registrants of the designated professions. (Health and Social Care Professionals Act 2005).

As a background to the running of CORU, the Professions Governed by the Health and Social Care Professionals Act 2005 include; Clinical Biochemists, Dieticians, Medical Scientists, Occupational Therapists, Orthoptists, Physiotherapists, Psychologists, Radiographers & Radiation Therapists, Social Workers, Social Care Workers, Speech & Language Therapists and Podiatrists.

The functions of CORU include; Registration; Fitness to Practice; Code of Professional Conduct & Ethics; Education; CPD. In relation to Opticians, from late 2008, the Government announced the Opticians Board was to join CORU. In May 2014 the Interim Optical Registration Board was established.

In preparation for the transfer, standards are being developed in conjunction with the Interim Optical Registration Board. The professional members include Peter McGrath (Chair), Eilis Dolan-English, Owen Blee, Vivienne Starr, Peter Davison and Norma Judge. The lay members include Seamus Boland, Patricia Logan, Martin Coyne, Charles Irwin, Ann Sheehan, John Doran and Majella Daly.

The setting of standards will be ensured through the Code of Professional Conduct and Ethics and also Fitness to Practice. Education and Training will be backboned by the; Criteria & Standards of Proficiency; Approval & Monitoring of Education Programmes and Continuing Professional Development (CPD).

Before a register is opened, each registration board makes three Statutory Instruments (bye-laws), these are Approved Qualifications; Code of Professional Conduct & Ethics and Application for Registration.

Specific to the Optical Registration Board, there will also be the Dispensing of Spectacles, Contact Lens, Review of Rules transferred from Optician Boards, Returners to Practice and Restoration to the Register.

Public consultations will in time take place for all Statutory Instruments (bye-laws) and also Fitness to Practice.

Fitness to Practice is about finding out if a registered professional is unfit to practice and, if so, taking the appropriate steps to remedy the situation. If a registered professional is unfit to practice, they put the safety of the public at risk and with this in mind Fitness to Practice will commence on 31 December 2014. Optometrists and Dispensing Opticians will be subject to Fitness to Practice on transfer of their registers from the Opticians Board.

## *Appendix 17: Submission from the National Council for the Blind Ireland (NCBI)*

Over the past number of years payment for low vision aids has been restricted in some HSE Local Health Offices (LHOs) and in others payment has stopped entirely. This means that after assessment individuals have to fund any equipment which they require. While the inequality of this system is apparent, it seems to depend entirely on your location, it also has a lasting effect resulting in increased dependence on others to carry out basic tasks, feelings of isolation and also placing a substantial financial burden on the individual.

NCBI has spent substantial resources equipping regional centres to ensure that as far as practicable all of their services are accessible country wide and close to the service user, aligning comfortably with the general healthcare policy of moving care from acute settings to the community. However, access to community ophthalmic services have been shown to be under resourced both in the numbers of community ophthalmologists and in the specialist services which are available. If access to community ophthalmic services is restricted then it follows that those who could benefit from referral to NCBI do not do so, further adding to the burden on other services in the community. So much so that 'The Economic Cost of Vision Impairment and Blindness in the Republic of Ireland<sup>47</sup>' paper states the following; 'compared to people who are not vision impaired, people with vision loss experience':

- A reduced quality of life
- Greater difficulty with daily living and social dependence
- Higher rates of clinical depression
- A higher risk of early death
- An increased risk of falls and related hip fractures
- Premature admission to nursing homes

'The Economic Cost of Vision Impairment and Blindness in the Republic of Ireland<sup>47</sup>' paper highlights 5 key steps which will help reduce the burden of vision impairment on the individual, health and social care services and ultimately to the state, these are:

1. Coordinate greater screening of high risk groups including people with diabetes and the elderly; the prevalence of vision impairment due to longevity and non-communicable chronic diseases is increasing, particularly in developed countries such as Ireland.
2. Provide more funding to hospital ophthalmology units, to reduce waiting lists for cataract surgery and other eye procedures to correct sight loss.
3. Encourage all Irish citizens to undergo an eye examination, at least every 2 years.
4. Promote the clinical importance of 'mild' vision impairment, which impacts everyday activities and often progresses to more severe loss.
5. Target earlier treatment of eye diseases that impair vision, such as AMD, cataract and glaucoma.

### **Conclusion**

It is the belief of NCBI as outlined in the **'Framework to Adopt a Strategic Approach for Vision Health in Ireland<sup>3</sup>'** that the Primary Care Eye Services Review Group in conjunction with a National Vision Strategy will provide a means to:

1. Move towards the elimination of avoidable sight loss,
2. Rebalance the focus of prevention and early intervention, and
3. Provide equitable access to efficient and high quality care, supports and treatment.

## Appendix 18 Existing 'Can Your Baby See?' Questionnaire

### Can your baby see well?

*An bhfuil an radharc go maith ag do leanbh?*

 Tick either yes or no for each of the signs as you notice them

When checking how well your baby sees, make sure you do not make a sound. If you are worried about your baby's eyesight at any age, talk to your public health nurse. Please take your baby to the routine eye checks at your local child health clinic.

		Yes	No
<b>By 2 months</b>	Your baby looks at you, follows your face and smiles back when you smile	<input type="checkbox"/>	<input type="checkbox"/>
	Eyes move together	<input type="checkbox"/>	<input type="checkbox"/>
	Is there any sign of a squint (lazy eye)?	<input type="checkbox"/>	<input type="checkbox"/>
	Does baby turn towards light?	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
<b>By 6 months</b>	Your baby looks around with interest	<input type="checkbox"/>	<input type="checkbox"/>
	Tries to reach out for small objects.	<input type="checkbox"/>	<input type="checkbox"/>
	Do you think there is a squint (lazy eye)? (A lazy eye at this age should be examined even if slight or temporary)	<input type="checkbox"/>	<input type="checkbox"/>
<b>By 9 months</b>	Does baby poke and rake with hands amongst very small objects?	<input type="checkbox"/>	<input type="checkbox"/>
	Your baby may be able to watch and follow a toy falling off the table.	<input type="checkbox"/>	<input type="checkbox"/>
<b>By 12 months</b>	Does your baby point to things she/he wants?	<input type="checkbox"/>	<input type="checkbox"/>
	Does your baby recognise familiar people when they come into a room, before they speak?	<input type="checkbox"/>	<input type="checkbox"/>

### Your baby's vision

*Radharc do linbh*

Here are some of the signs of normal vision to look out for during your baby's first year.

page 21a

## Can your baby see?

There is no easy way to test a young baby's eyes accurately, but you can help check there is no serious problem by watching how your baby uses his/her eyes. **Talk to your health visitor or GP as soon as possible if you are ever worried about your child's eyes or vision.**

### At all ages

If you notice any of the following: an opaque or white reflection in the pupil (dark area in centre of the eye); a change in colour of the iris (the coloured part of the eye); or the 'red eye' reflection missing or altered in a photograph, take your child to see a doctor as soon as possible.

#### First two months

*Your child's eyes will be examined as part of the routine baby review during this period*

	Yes	No
Does your baby open his/her eyes and look at you?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby look at you when you move your head from side to side?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed anything unusual about or in your child's eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in the family have serious eye disease that started in childhood?	<input type="checkbox"/>	<input type="checkbox"/>

#### Babies and toddlers

Does your baby ever seem to have a squint (a 'turn' or a 'lazy' eye)?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby have any difficulty in seeing small objects (tiny bits of food, crumbs, bits of fluff) or recognising familiar people?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in the family have a squint (a 'turn' or a 'lazy' eye), or wear glasses (starting in childhood)?	<input type="checkbox"/>	<input type="checkbox"/>

#### Age two to school entry

Your child should be offered a vision test as part of their routine school entry physical examination (between 4 and 5 years). If you are concerned before that test is done, for example that your child may need glasses, talk to your doctor or health visitor.

Does your child have any squint (a 'turn' or a 'lazy' eye) or any difficulty in seeing (e.g. watching T.V., recognising you across a room, bumping into things, being unusually clumsy)?	<input type="checkbox"/>	<input type="checkbox"/>
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## Appendix 19 Updated 'Can Your Baby See?' Questionnaire

### Can your Baby See?

There is no easy way for you to test a young baby's eyes accurately, but you can help check there is no serious problem by watching your baby use his/her eyes. Talk to your Public Health Nurse or GP as soon as possible if you are ever worried about your child's eyes or vision.

### At all ages

If you notice any of the following: an opaque or white reflection in the pupil (dark area in centre of the eye), a change in the colour of the iris (the coloured part of the eye), or the "red eye" reflection missing or altered in a photograph, take your child to see a doctor as soon as possible.

### Family History

	Y	N
Does anyone in the family (i.e. parent or sibling) have?	<input type="checkbox"/>	<input type="checkbox"/>
• A squint/turn/cast in the eye	<input type="checkbox"/>	<input type="checkbox"/>
• Amblyopia/'lazy eye' (reduced vision in one eye, often treated by patching)	<input type="checkbox"/>	<input type="checkbox"/>
• Glasses needed from a young age (i.e. prior to 5 years old)	<input type="checkbox"/>	<input type="checkbox"/>

### By two months

Does your baby open his/her eyes and look at you?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby look at you when you move your head from side to side?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby smile back when you smile	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed anything unusual about or in your child's eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any sign of a squint (a "turn" or "lazy" eye)?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby turn towards light?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone in the family have serious eye disease that started in childhood?	<input type="checkbox"/>	<input type="checkbox"/>

### By 6 months

Does your baby look around with interest?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby try to reach out for small objects?	<input type="checkbox"/>	<input type="checkbox"/>
Does your baby ever seem to have a squint (a 'turn' or a 'lazy' eye)?	<input type="checkbox"/>	<input type="checkbox"/>

### By 9 months

Does your baby poke and rake with hands amongst very small objects?	<input type="checkbox"/>	<input type="checkbox"/>
Your baby may be able to watch and follow a toy falling off the table	<input type="checkbox"/>	<input type="checkbox"/>

**By 12 months**

Does your baby point to things she/he wants?

☐ ☐

Does your baby have any difficulty in seeing small objects (tiny bits of food, crumbs, bits of fluff) or recognising familiar people?

☐ ☐
**By 2 years**

Does your toddler sort blocks by shape and colour?

☐ ☐

Does your toddler pick up small objects?

☐ ☐

Does your toddler recognise pictures of animals or everyday objects, e.g. a cup, in a picture book?

☐ ☐
**By 3 ½ - 4 years**

Does your child have any squint (a 'turn' or a 'lazy' eye)

☐ ☐

Does your child have any difficulty in seeing e.g. watching T.V., recognising you across a room, bumping into things, being unusually clumsy?

☐ ☐
**School entry**

Your child will be offered a vision test as part of their routine school health programme (usually junior infants). If you are concerned before that test is done, for example that your child may need glasses, talk to your doctor or Public Health Nurse.

**ADDITIONAL INFORMATION WHEN REFERRING (This is mostly from Unit 2 Vision Screening, BHFC)****1. FAMILY HISTORY OF SQUINT**

Please clarify when taking history. The word squint is sometimes misunderstood.

True squint should have some form of treatment in childhood, i.e. glasses, patching or surgery. Only refer cases where parents or siblings have a definite squint and there is parental concern. If there is no parental concern, advise parent to monitor their child's vision and if they have any concerns to contact the PHN..

**2. FAMILY HISTORY OF GLASSES**

Only immediate family (parents/siblings) who has worn glasses from under age 5 years. Here we are looking principally for hypermetropia and anisometropia. School age myopia does not require screening at this age. Congenital myopia is rare.

**3. CONCERN ABOUT POSSIBLE SQUINT**

Refer all cases with a definite diagnosis of constant or intermittent squint by the PHN

**4. CONCERNS ABOUT EYE MOVEMENT**

Refer all cases of ocular motor imbalance, or where parents are concerned with their child's eye movements.

**5. CONCERN ABOUT VISION**

Following examination or concerns from parents.

## **6. HISTORY OF PREMATURITY**

All babies born less than 31 weeks gestation or less than 1.5kg are examined by an ophthalmologist in the Special Care Baby Unit. These babies are followed up until school entry by a community based or hospital based ophthalmologist. The schedule of follow up visits varies according to whether the child has had treatment for retinopathy of prematurity or whether they have other visual problems diagnosed by the ophthalmologist. The public health nurse should enquire of the parents at all visits whether the child has ongoing care with an ophthalmologist

## **7. Fine motor skills**

Much of a child's motor development in the early years is vision dependent. Therefore, if there is a concern about a child's vision consider asking when did the child first walk and review fine motor coordination.



