Northern Ireland
Diabetic Eye
Screening
Programme

Appendices

Consultation on the way the Northern Ireland Diabetic Eye Screening Programme is provided

This document relates to Consultation Paper Version 4.5

Contents

APPENDIX 1 - DESP Modernisation Project Board

1. Purpose

The DESP Modernisation Project Board is chaired by the Director of Public Health. As the Senior Responsible Officer (SRO) the Assistant Director for Screening and Professional Standards is accountable to the Project Sponsor, the Director of Public Health.

Through the executive authority of its members, this group is responsible for the DESP Modernisation Project to a high quality, on an equitable and sustainable basis, for the eligible population of Northern Ireland;

2. Objectives

a) Making decisions based on Project Board consensus;
b) Approving the Project Initiation Document (PID);
c) Nominating the Project Team Chair and members;
d) Directing the project, providing guidance and ensuring adherence to the timed Project Plan;
e) Reviewing and approving the timed Project Plan and any changes to it;
f) Reviewing each completed stage of the project and approving progress to the next stage, ensuring that all stages are delivered in line with the agreed project plan, resources and timetable;
g) Monitoring and controlling the progress of the project at a strategic level;
h) Committing project resources, recommending expenditure and agreeing tolerance levels for each stage;
i) Ensuring the project meets agreed standards of quality, time and cost;
j) Consulting and communicating with all relevant professional groups and appropriate bodies regarding the development of the programme;
k) Representing the project within health and social care and beyond;
l) Providing assurance that all products have been delivered satisfactorily;
m) Developing proposals to establish future quality assurance, performance management, programme management and commissioning structures and arrangements;
n) Authorising project closure; and
o) Conducting post project review if required.

3. Membership of the Diabetic Eye Screening Project Board

Constituent	Name	Job Title	Organisation
Chair	Dr Adrian Mairs	Acting Director of Public Health	PHA
DoH Lead	Dr Carol Beattie	Senior Medical Officer	DoH
Clinical Lead	Prof Tunde Peto	Consultant Ophthalmologist	BHSCT
BHSCT Lead	Stephen Boyd	Co-Director, Division of Surgery & Specialist Surgery	BHSCT
PHA Lead	Dr Stephen Bergin	Acting Assistant Director of Screening and Professional Standards	PHA
Programme Manager	Claire Armstrong	QA and Programme Development Manager, NI DESP	PHA
ITS Lead	tbc		
Integrated Care	Dr Mary Donnelly	GP Medical Advisor	HSCB
Voluntary Sector	Brendan Heaney	Policy and Public Affairs Manager	Diabetes UK
Voluntary Sector	David Galloway	Director, RNIB NI	RNIB

The chair and the project board can co-opt further members as necessary.

APPENDIX 2 - DESP Modernisation Project Team

1. Purpose

The Project Team's will produce all project products and outcomes to required quality standards and within agreed timescales and cost.

Project Team members are required to represent the views of their professional group, or constituency, rather than those of their employing organisation. They are responsible for consulting with and bringing the views of their colleagues to the Project Team, and for communicating progress back through relevant structures on a regular basis.

The Project Team has responsibility for strategic issues.

2. Objectives of the Project Team

To work closely with the Project Team Chair and Project Manager to:

a) Prepare a timed Project Plan for submission to the Project Board for approval. The project plan will include:
   I. Identifying the requirements for a high quality screening service;
   II. Identifying the information and IT requirements for:
      - A call/recall system including failsafe
      - Storing images
      - Monitoring standards and quality assurance for the programme.
   III. Developing public information including letters of invitation for screening, information leaflets, information for primary care and healthcare staff and a public information campaign;
   IV. Ensuring the development of agreed policy, procedures and quality standards for all aspects of the Diabetic Eye Screening Programme, which take account of standards within similar programmes in Great Britain;
   V. Estimating the resource implications of:
      - Maintaining and modernising a coordinated high quality screening programme; and
      - Ensuring referral for treatment and care of people identified with sight threatening diabetic retinopathy as a result of the screening programme
   VI. Developing a timetable for the roll out of the DESP Modernisation Project.
   VII. Producing a screening manual outlining policy and procedures for each aspect of the project; and
   VIII. Updating the quality assurance structure for the Diabetic Eye Screening Programme.

b) Consult with and represent the views of colleagues from each member's own profession across Northern Ireland, keeping them informed of the process;

c) Prepare progress reports and other required documentation for submission to the DESP Modernisation Project - Project Board for review and approval;

d) Ensure that all elements of the plan/products are delivered on time and within budget;

e) Ensure that there is no duplication of effort between working groups in delivering interrelated products and that no work is overlooked;

f) Advise, make recommendations and report progress against agreed milestones to the DESP Modernisation Project - Project Board;

g) Advise the DESP Modernisation Project - Project Board of forecast deviations outside the agreed Project Plan and budget;

h) Manage project issues, risks and develop contingency plans as appropriate;

i) Undertake appropriate consultation with relevant stakeholders; and

j) Ensure that quality criteria and checking arrangements have been developed for all products and assist in monitoring the project.

3 Membership

*While members have specific areas of responsibility all members are expected to contribute to the overall success of the project.

Name	**Organisation**
Stephen Bergin, Chair	PHA
Claire Armstrong	PHA
Fiona Morgan	PHA
Rosemary Bowles	BHSCT
Mary Hanrahan	BHSCT
Tunde Peto	BHSCT
David McCance	BHSCT
tbc	NIGPC
Lesley McGrann	BSO-ITS
Lesley Hamilton	WHSCT
Asif Orakzai	WHSCT
Raymond Curran	HSCB
Mary Donnelly	HSCB

APPENDIX 3 – Overview of Model Options

Option 1 – Existing Model

In this option the current models would remain unchanged.

Advantages	
Participants	• Convenience of attending at your GP practice • High degree of satisfaction
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services • High degree of satisfaction
Standards/Service	
Disadvantages	
Participants	• Restricted choice regarding date, time and location of screening appointment
Primary Care	• Continued pressure on primary care to provide suitable accommodation
Standards/Service	• Probably unsustainable given the increasing diabetic population and its rate of growth • Unable to meet standards in particular the screening interval standard throughout Northern Ireland • Staff dissatisfaction • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual. • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing

Option 2a – Regional Fixed HSC Sites

This model would provide the service at HSC locations e.g. local hospitals, community hospitals, health and wellbeing centres, and suitable larger GP practices. The screening technicians would provide screening clinics in at least 22 fixed HSC sites throughout Northern Ireland (including the current 6 sites in WHSCT). Whenever required and possible, they would work in pairs for support, making it less likely that a screening clinic would be cancelled if a screening technician was unavailable.

Advantages	
Participants	• Choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened, rather than having to travel to Belfast to a "mop up" clinic.
Primary Care	• Remove pressure on primary care to provide rooms on an annual basis
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Ability to maintain practice of fixed appointments • Improved ability to meet standards, in particular screening interval • Suitable rooms are available when required • Enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease • Improved job satisfaction for staff, particularly screener/graders • Improved efficiencies; travel, set-up and closedown times, manual handling
Disadvantages	
Participants	• Potential for increased travel for some people
Primary Care	• Reduced ability to integrate retinal photography with other diabetic care services. However this would depend on the HSC sites chosen, for example, foot clinics or dietetic clinics could be co-located.
Standards/Service	

Option 2b – Regional Fixed Primary Care Sites

This model would provide the service within selected groups of GP practices, identified in collaboration with LMCs. The screening technicians would provide screening clinics in at least 22 fixed HSC sites throughout Northern Ireland (including the current 6 sites in WHSCT). Whenever required and possible, they would work in pairs for support, making it less likely that a screening clinic would be cancelled if a screening technician was unavailable.

Advantages	
Participants	• Choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened.
Primary Care	• Would remain actively engaged in the programme, although not at individual practice level.
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Improved ability to meet standards, in particular screening interval • Suitable rooms may be available when required • Should enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease • Improved job satisfaction for staff, particularly screener/graders • Improved efficiencies; travel, set-up and closedown times, manual handling
Disadvantages	
Participants	• Potential for increased travel
Primary Care	• Reduced ability to integrate retinal photography with other diabetic care services. However this would depend on the HSC sites chosen, for example, foot clinics or dietetic clinics could be co-located.
Standards/Service	• May not be able to leave the cameras in the identified primary care accommodation permanently, meaning some degree of transportation will be required

Option 3 – Regional Mobile Service

This service would retain the current mobile service in the BHSCT, NHSCT, SEHSCT and SHSCT areas and expand the mobile service into the WHSCT area.

Advantages	
Participants	• Increased number of locations in the western area • Regional model, i.e. equity of service for all trust areas
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services for western area GPs
Standards/Service	
Disadvantages	
Participants	• Restricted choice regarding date, time and location of screening appointment
Primary Care	• Continued pressure on primary care to provide suitable accommodation
Standards/Service	• Unsustainable given the increasing diabetic population and its rate of growth • Unable to meet standards in particular the screening interval standard throughout Northern Ireland • Staff dissatisfaction • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual. • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing

Option 5 – High Street Optometry Based Service

In this model screening (i.e. photography only) would be carried out in around 60 high street optometry practices throughout Northern Ireland. Laptops (or PCs) would be provided to each practice and all screening participants would continue to be appointed and managed on the OptoMize system. Therefore training would be required for each practice. Further to this training, each screening optometrists would be required to complete the National Health Screener Qualification and attend local training events held for the screening team every month. Whilst it is recognised that high street optometrists would find it difficult to attend for one day per month, at a minimum each optometrist carrying out screening would be required to attend at least 10/12 sessions. Induction training would also need to be completed to ensure that each screening optometrist is familiar with, for example, the programme, its aims, standards, training requirements, imaging requirements, reporting mechanisms, procedures and processes.

It should again be re-emphasised at this point that all grading, further examination, surveillance appointments and onward referral to Hospital Eye Services would be carried out by the screening team employed by Belfast HSC Trust.

Feedback from a small number of the pre-consultation respondents (7 from the optometry sector) suggested an alternative model. This proposed model would allow all optometry practices across Northern Ireland to provide Diabetic Eye Screening. However given that there are around 275 optometry practices with approx. 500WTE Optometrists in NI to a population of around 91,000 (2016/17). This would potentially mean each optometrist screening less than 200 people per year. Also the amount of administration, governance and monitoring that would be required would render this suggested option unfeasible.

Advantages	
Participants	• Choice of venue to attend for screening and patient could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened,
Primary Care	• Pressure removed from primary care to provide accommodation
Standards/Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease
Disadvantages	
Participants	• Screening provided in commercial premises
Primary Care	
Standards/Service	• Reduced control over the meeting of quality standards, in particular the screening interval • Programme would struggle to meet the training requirements for 60 optometry practices • Difficulty in monitoring practice of large number of optometrists to ensure imaging is of sufficient standard and following screening protocols • Maintenance of software and potentially hardware in 60 practices • Ensuring data protection, information governance, particularly in light of new GDPR rules is appropriate • May result in a move back to open appointment system • Cost

Option 7a – Mixed Model – Mobile and Fixed Site

This model would provide the service at those GP practices who wish to maintain the service along with a number of fixed locations in areas where there is no GP service available. This retains the disadvantages of the current mobile service.

Advantages	
Participants	• Convenience of attending at your GP practice remains for some participants
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services for those practices who wish to retain the service
Disadvantages	
Participants	• Restricted choice for some regarding date, time and location of screening appointment • Would result in an inequitable service for users, dependent upon their area of residence or registered GP
Primary Care	• Continued pressure on participating practices to provide suitable accommodation • Reduced ability to integrate retinal photography with other diabetic care services within certain practices
Standards/ Service	• Probably unsustainable given the increasing diabetic population and its rate of growth • Unable to meet the screening interval standard • Staff dissatisfaction • Inefficient use of resources • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual as we are unable to run a programme based on individual screening intervals and practice screening intervals simultaneously (the IT system can't accommodate this). • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing for some participants

Option 7b – Mixed Model – HSC Fixed Sites and High Street Optometry

This model would provide the service at a number of fixed sites and at a number of (around 30) community optometry practices.

Advantages	
Participants	• Choice of venue to attend for screening and could, for example, select the nearest to their home, or to their place of work • Anyone who cannot attend when invited would also be able to select where to be screened,
Primary Care	• Pressure removed from primary care to provide accommodation
Standards/ Service	• Invites would be based on the individual; rather than when a practice population is due to be screened • Improved ability to meet the screening interval standard for those within fixed HSC sites • Enable the addition of visual acuity testing to the screening programme • Enable the introduction of the 24 month interval for those assessed to be at lower risk of diabetic eye disease
Disadvantages	
Participants	• Screening provided in commercial premises
Primary Care	• Reduced ability to integrate retinal photography with other diabetic care services. However this would depend on the HSC sites chosen, for example, foot clinics or dietetic clinics could be co-located.
Standards/ Service	• Reduced control over the meeting of quality standards, in particular the screening interval for those being seen in community optometry • Programme would struggle to meet the training requirements for 30 optometry practices • Difficulty in monitoring practice of large number of optometrists to ensure imaging is of sufficient standard and following screening protocols • Maintenance of software and potentially hardware in 30 practices • Ensuring data protection, information governance, particularly in light of new GDPR rules is appropriate • May result in a move back to open appointment system • Cost

Option 7c – Mixed Model – Mobile and High Street Optometry

This model would provide the service at those GP practices who wish to maintain the service along with (around 40) high street optometry practices.

Advantages	
Participants	• Convenience of attending at your GP practice remains for some participants
Primary Care	• Opportunity to integrate retinal photography with other diabetic care services for those practices who wish to retain the service
Standards/ Service	
Disadvantages	
Participants	• Would result in an inequitable service for users, dependent upon their area of residence or registered GP • Restricted choice for some regarding date, time and location of screening appointment
Primary Care	• Continued pressure on participating practices to provide suitable accommodation • Reduced ability to integrate retinal photography with other diabetic care services for some practices
Standards/ Service	• Probably unsustainable given the increasing diabetic population and its rate of growth • Unable to meet the screening interval standard • Staff dissatisfaction • Inefficient use of resources • Continued wear and tear on equipment • Screening will continue to be organised according to participant's GP practice not by individual as we are unable to run a programme based on individual screening intervals and practice screening intervals simultaneously (the IT system can't accommodate this). • Service will be unable to introduce variable screening interval • Inability to carry out visual acuity testing for some participants • Cost

APPENDIX 4 – PRE-CONSULTATION STAKEHOLDER ENGAGEMENT

- **Primary Care Diabetes Society** (21st September) – brief presentation and copies of document and questionnaire to all attendees. Requested that electronic versions be sent to the society's distribution list.
- **NI General Practitioner Committee** (24th October) – presentation to the committee.
- **Western LCG** (8th November) – presentation to the group, some useful questions and discussion.
- **Diabetes Network** (10th November) – agreed with the Network's Project Manager that electronic version of the documents would be sent to those involved in each of the workstreams.
- **Screening Staff** (14th November) – presented to screening staff at their monthly training day on the pre-consultation process and documentation. Some useful discussion, importance of having their say in the process, emphasised, staff responses to the questionnaire subsequently received.
- **Southern LCG** (16th November) – provided a brief presentation.
- **Optometrists NI** (23rd November) – teleconference into the board meeting of the ONI, R Curran in attendance to provide further input and background. Engagement from members, resulting in numerous questionnaire responses from optometry community, including ONI and Royal College. ONI also notified their members of the pre-consultation process on their website.
- **Northern LCG** (23rd November) – provided a brief presentation.
- **South Eastern LCG** (7th December) – provided a brief presentation.
- **Belfast LCG** (21st December) – provided a brief presentation. Discussion of pre-consultation process at length and representation present from optometry sector
- **Diabetes UK NI** – documentation was sent out to 50 of their members for completion.
- **RNIB** – request to distribute 50 copies to members.
- **Screening Clinics** - Screener/Graders handed out 50 copies within each trust area to those attending for screening. A further 80 copies were distributed within suitable HES clinics.
- **Online** - the pre-consultation document and response questionnaire were added to the PHA website (link included in the document also); http://www.publichealth.hscni.net/modernising-diabetic-eye-screening-programme
- Diabetes UK NI (29th November) – to present at the DUK Voluntary Group event, to be attended by representatives of the 26 NI user groups. This event was cancelled by organisers
- Integrated Care Partnership Leads (13th December) – This meeting was cancelled by organisers
- Trust Chief Executives (18th December) – This event was cancelled by organisers

APPENDIX 5 – PRE-CONSULTATION RESULTS OVERVIEW

Options	**Yes**	**No**	**N/A**
1. Do you agree that the current service delivery model needs to change?	30	8	1
2. Are there any other options we should consider?	18	19	2
3. Have all the advantages and disadvantages of the different models been identified?	24	12	3
Options Appraisal			
4. Are the option appraisal objectives appropriate?	34	2	3
5. Do you agree with the weighting given to the objectives?	28	6	5
6. Do you agree with the short list of options?	28	7	4
Equality			
7. When you think of the range of people … difficulties under any of the model options?	18	17	4
8. What do you suggest we could do to address these difficulties/needs?	20 comments		
Rural Impact			
9. Are there implications for rural areas we need to consider?	26	8	5
Final Comments			
10. Do you have any other comments?	26 comments		

Question 1: the 8 respondents who disagreed that the model needs to change were all members of the public who were happy with the current service provision.

Question 2**:** there were 18 respondents who stated that other options should be considered, however many of these respondents did not suggest an alternative. There were however 7 questionnaires from the optometry sector

that suggested a model were all optometry practices would be able to provide screening services.

Question 3: 62% felt that all advantages and disadvantages had been included. The responses of those who stated 'no' highlighted a degree of confusion regarding the potential role of community optometrists and the aim of screening.

Question 4: there was a clear majority (87%) of respondents who felt that the appraisal objectives were appropriate. In the case of the 2 respondents who answered 'no', one sought further clarity on the meaning of the objectives, the other disagreed with the weighting rather than the objectives themselves.

Question 5: 72% agreed with the weighting, those who disagreed felt that accessibility and patient choice should be higher and quality lower.

Question 6: 72% agreed with the shortlist of options. There were further comments on the suggested model in Question 2, i.e. that all optometry practices could participate.

Questions 7&8: there were a significant number of comments on the issue of equality. Whilst some responses were not directly relatable to an equality grouping, the key themes were around the elderly, those in rural areas, with limited mobility or with physical or sensory disabilities. In terms of solutions transport and its availability and use of interpreters were some of the common suggestions.

Question 9: the majority (67%) felt there would be implications for those in rural areas. As in questions 7 and 8 many of the responses were around the issues of transport and accessibility of screening locations.

Question 10: there were 26 questionnaires which included final comments. Half of these comments were around the use of community optometry in DESP. They sought further clarity on the costing of this model, the potential role of optometrists and also to highlight again the advantages of the community optometry model.

APPENDIX 6 - Summary of estimated revenue and capital costs for each option

	Option 1	Option 2a	Option 2b	Option 3	Option 5	Option 7a	Option 7b	Option 7c
	Existing model	**Fixed location – HSC sites**	**Fixed location – selected GP federation practices**	**Regional mobile service provided at individual GP surgeries**	**Community optometrist**	**Individual practice based service PLUS fixed sites**	**Fixed location PLUS community optometrists**	**Individual practice based service PLUS community optometrists**
Revenue costs pa (millions)	£1.39m	£1.48m	£1.48m	£1.33m	£1.93m – £2.21m	£1.39m	£1.81m - £1.95m	£1.73m - £1.91m
Cost per capita (eligible pop'n)	**£15.22**	**£16.19**	**£16.19**	**£14.59**	**£21.22 - £24.22**	**£15.22**	**£19.89– £21.39**	**£18.98 - £20.96**
Capital (One-off)	£16,000	£100,000	£100,000	£57,000	£72,000 - £105,000	£16,000	£58,000 - £74,500	£54,000 - £76,000
Capital (Recurrent)	£37,800	£33,700	£33,700	£36,000	0	£37,800	£33,700	£18,000
Capital Costs	**£53,800**	**£133,700**	**£133,700**	**£93,000**	**£72,000 - £105,000**	**£53,800**	**£91,700 - £108,200**	**£72,000 - £94,000**

APPENDIX 7

Freedom of Information Act 2000 – Confidentiality of Consultations

The Public Health Agency will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Agency can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, in this case the Agency. This right of access to information includes information provided in response to a consultation. The Agency cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances.