UKOA
UK OPHTHALMOLOGY ALLIANCE

Spreading best practice
UK Ophthalmology Alliance

Funded by
NATIONAL ORTHOPAEDIC ALLIANCE VANGUARD
Networked care

Contents

Biography

Melanie Hingorani MA, MBBS, MD, FRCOphth

Melanie is a consultant ophthalmologist specialising in paediatric ophthalmology and ocular motility at Moorfields Eye Hospital NHS Foundation Trust. She has a subspecialist interest in paediatric external eye disease and corneal disorders. Melanie is passionate about clinical governance and safety in ophthalmic care.

Melanie was clinical director, quality and safety at Moorfields for six years and clinical lead for the Moorfields vanguard programme from 2015–2018. As part of that work, she led the establishment of and became the inaugural chair of the UK Ophthalmology Alliance.

She is a member of the national ophthalmic audit steering group, chair of professional standards at the Royal College of Ophthalmologists and sits on the college scientific committee and the college council.

Vanguard programme editorial team:

Johanna Moss Programme executive lead

Karen Reeves Programme director

Philippa Hutchinson Programme content manager

Brian Donnelly Programme communications lead

1. Introduction

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme.

This represented one of the first steps towards delivering the NHS England Five Year Forward View by supporting the improvement, standardisation and integration of services. Moorfields Eye Hospital (Moorfields) was successful in bidding to become one of 13 acute care collaborative vanguard programmes.

In April 2017 the Moorfields vanguard team published a unique e-toolkit **(www.networkedcaretoolkit.org.uk)** sharing findings from our research into best practice for single specialty networked care.

One of the key learnings from this research was the impact that standardisation and collaboration can have on improving clinical outcomes. Building on that theme we have established the UK Ophthalmology Alliance (UKOA), consisting of NHS ophthalmic providers and other key stakeholder organisations working together on best practice initiatives.

Working with the National Orthopaedic Alliance (NOA) vanguard programme we have replicated its alliance membership model. This publication shares our experience and advice from replicating the NOA model across ophthalmology nationally.

Moorfields Eye Hospital was successful in bidding to become one of

13

acute care collaborative vanguard programmes

2. What is the National Orthopaedic Alliance?

First formed in the early 2000s, the Specialist Orthopaedic Alliance (SOA) was a coalition of hospitals and other providers which contributed significantly to raising the quality of care for orthopaedic patients in England.

National vanguard funding was secured to develop the model and increase membership. In July 2017 the SOA became the National Orthopaedic Alliance (NOA). By providing a group voice for high volume and specialist orthopaedic providers, close links to the Getting It Right First Time programme (GIRFT) and additional activities such as benchmarking, mentoring and buddying, alliance members have been leading the way in delivering better care and value through improved outcomes and productivity.

40

trusts are now members of NOA

The aim of the NOA vanguard programme was to create a UK-wide alliance of orthopaedic providers to deliver outstanding and consistent care in more areas. The NOA vanguard has developed a consistent benchmarking framework, describing not only 'what good looks like' in orthopaedic care but also the components of a quality improvement journey. The alliance partners participate in self-assessments against those standards as well as creating a standardised toolkit to drive quality improvements in other orthopaedic providers across the NHS. Forty trusts are now members.

Clinical and managerial staff from member units collaborate to produce standards and recommendations, with related metrics, based on high quality relevant evidence from comprehensive literature reviews, published national guidance (eg NICE, royal colleges) and GIRFT, together with expert consensus views. The NOA members work together to:

- establish agreed quality standards, best practice pathways and service specifications with benchmark targets.
- share a dedicated web portal populated by NHS digital data and provider-supplied data, informed by GIRFT results, allowing benchmarking of processes and outcomes to drive up standards.
- provide peer-led buddying and support to improve quality areas between providers with better outcomes and those with lower outcomes.
- create a powerful voice which can negotiate locally and nationally for the benefit of orthopaedic commissioning and resourcing and which champions the specialty.

Develops coding standards, offers training, buddying support and e-newletters.

Developed 120 quality standards in 28 areas.

3. Why was ophthalmology chosen to replicate the NOA model?

A key driver for all vanguards was to create replicable blueprints that could be rolled out quickly elsewhere in the NHS. The NOA programme was funded on the basis that its alliance model could be replicated across other, non-orthopaedic, specialties.

As single specialty vanguards, Moorfields and the NOA had already developed a relationship through the national vanguard programme. Moorfields also has close relationships with other key national eye care bodies and several of our clinical staff are in leadership roles nationally within the standards, efficiency and commissioning arenas, including GIRFT. The vanguard clinical lead, Melanie Hingorani was clinical director for quality and safety at Moorfields for a number of years and, at the time of this publication, is chair of professional standards for the Royal College of Ophthalmologists.

These factors were instrumental in ophthalmology being identified as a specialty likely to be able to replicate the NOA model in year two of Moorfields' vanguard programme.

It was therefore agreed that an ophthalmology alliance would be developed as part of the NOA vanguard programme in 2017/18, but driven clinically by the Moorfields programme team.

Building on the UKOA experience, this publication shares learning to help other specialties develop their own alliance model.

Moorfields and the NOA had already developed a relationship through the national vanguard programme.

4. When is an alliance model a good fit?

Before any work is undertaken it is helpful to think through the reasons for forming an alliance model.

It is also useful to ensure there is sufficient interest. The concept should be discussed informally with other provider and stakeholder colleagues to ensure that the work involved in planning is supported. It is useful to consider whether:

- the specialty is well-defined.
- the specialty has defined quality metrics or standards, not necessarily with consistent national performance.
- the specialty providers have shared concerns that would benefit from national collaboration; these could include funding, resourcing, efficiency or workforce.
- interested clinicians, managers and executives will want to get involved.
- the specialty providers and stakeholders are willing to work together.
- existing work is being led on quality improvement by other organisations, for example professional colleges.
- a more focused alliance (in geography or ambition) is workable if a full alliance is not possible.

Before establishing the UKOA, the clinical lead for the Moorfields' vanguard programme contacted a number of providers and stakeholders to gauge interest. This indicated sufficient interest to warrant an inaugural meeting.

5. How do you secure funding?

The ophthalmology alliance was fortunate to be funded from the national vanguard programme in 2017/18. However the fixed term nature of this funding created challenges.

The first alliance meeting was held in August 2017 and this left only seven months to establish a functioning alliance. Replication of the NOA model enabled progression at the fast rate needed.

It was clear the alliance would not be mature enough to become self-funding through membership contributions by March 2018 and members were keen not to lose the progress made. GIRFT was approached and agreed to fund the clinical lead for a further year as the alliance would be a vehicle to help GIRFT implement its findings nationally.

A key ambition for the UKOA, true to the collaborative spirit of the venture, is that governance is shared and not dependent on a single trust. It follows that the responsibility for funding the work is also shared. The aim is that the alliance will become self-funding from membership fees after March 2019.

An alliance model which has been established (NOA) and replicated successfully (UKOA) may provide evidence to support business cases for other specialties wanting to create their own alliance models.

In the early stages of developing an alliance model, funding will be needed for the clinical lead, project manager, administrative support, hospitality, literature reviews and communications support. Once established there will be costs for a website, newsletter and further literature reviews. The funding will need to cover these costs until the membership is established and fees are agreed or another funding source is identified.

The aim is that the alliance will become self-funding from membership fees after March 2019.

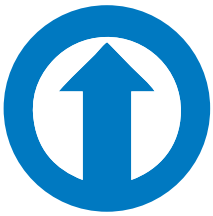
6. How to learn from existing alliances

The NOA pioneered the alliance model and those following can benefit from its experience. Learning from the UK Ophthalmology Alliance, the first specialty to replicate the NOA model, is now also available.

A key learning is not to replicate unthinkingly – consider how your specialty and what you need may differ. Our clinical lead attended the quarterly NOA meeting, observing and taking part in their activities; this helped to accelerate the UKOA replication process.

Understanding the challenges that NOA faced through developing the orthopaedic alliance will enable the ophthalmology alliance to better navigate its success. This in turn will help other specialties.

7. Leadership



The aim of any alliance will be to share governance between its members but in the early stages there has to be a core group driving the initiative.

It is very important that this is clinically led but has strong management support as well. Considerations include:

- Dual leadership is preferable; identifying senior clinical and managerial leadership accelerates implementation.
- The clinical lead must be a recognised speciality expert and/or work at a unit which is a recognised centre of excellence.
- Involving individuals who hold national positions of influence with professional colleges, regulators and commissioners will help to inform and influence the formation of an alliance. These individuals can also offer insight which helps to join up work across different organisations. This was key to establishing the UKOA.
- Leads benefit from a track record in clinical governance, clinical leadership and transformation.
- Leads benefit from close links with large or standalone units which are acknowledged to be the specialty leaders.
- Leads must have the support of their unit and executive decision makers. They will need to articulate the aims and benefits of an alliance early in the process.
- A dedicated project manager is needed to support the leads – this may be part-time or shared but the manager will need protected time to manage the administration. One day a week worked flexibly was successful for the UKOA, with some ad hoc additional hours when needed.

8. Clarify the aims and develop the message

The NOA has a very clear purpose to "create a powerful voice which can negotiate locally and nationally for the benefit of orthopaedic commissioning and resourcing and which champions the specialty".

This purpose has been adopted by the ophthalmology alliance and its principles exemplify the benefits of being part of an alliance model:

- one voice.
- power in numbers.
- forum for networking and learning.
- join expertise of clinicians with managers, trust and national agency leaders, all professionals, patients and commissioners among others.
- establish widely-accepted quality standards and best practice or efficiency pathways.
- provide or support web portals with activity and financial and quality data, allowing benchmarking to drive up standards.
- provide buddying, support and mentoring.
- lobbying and negotiation.

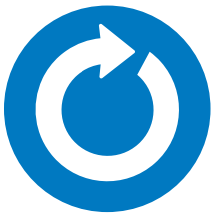
9. Founder members

There are benefits from making early, informal approaches to colleagues, other agencies and stakeholders (especially professional colleges and GIRFT).

They may be able to identify which units and people deliver good quality, want to improve the specialty, are likely to get involved and have experience in service transformation. Some factors to consider:

- What variation in provider units do you need? In smaller trusts executives may not see establishing an alliance as a priority and may be less likely to get involved. Larger units are more likely to take an early interest and get involved when the specialty represents an important proportion of their work. But you may need a balance between sizes of units to get a fair representation. National outpatient and surgical activity will help to understand unit size.
- Should single specialty providers and specialist units in multispecialty hospitals be involved?
- How will you ensure reasonable geographical spread?

10. Members and stakeholders – how inclusive?



It is important to consider how inclusive an alliance wishes to be. In the spirit of collaboration and shared governance, this has to be something the founder members discuss and agree.

There is a clear distinction between the numbers during the establishment phase and the reach of the alliance longer term. Considerations are likely to include:

- UK vs England vs regional.
- providers: aiming for all or just some – big specialist and/or district general hospitals (DGHs)?
- specialist societies.
- patient groups.
- charities and the voluntary sector.
- professional bodies including those from a whole multidisciplinary team.
- commissioners.
- any key workstream or agency in the sector.

It is also important to consider who will be members (those who pay), and who will be stakeholders (advised, informed and co-opted), who do some of the work.

Identifying key stakeholders outside the specialty is also important. These may include:

- procurement.
- regulators.
- national safety.
- GIRFT.

At this stage a number of carefully chosen founder members should be invited to ensure the alliance is manageable in the establishment phase, with a view to expanding membership later. Moorfields and the GIRFT clinical ophthalmology leads helped to identify appropriate founder members. The UKOA has 27 founder members (see annex A). SOA (now NOA) was originally established by five founder member organisations.

The UKOA is UK-wide and a mix of different sizes and types of unit were invited to join rather than starting with only the large specialist providers. Other specialties will need to consider what works best for their alliance model.

NHS ophthalmic providers delivering the greatest activity, having a reputation for quality and a good geographical spread, were invited to be founder members. To be as inclusive as possible the list also included smaller DGH ophthalmic providers with a good reputation for quality and influential organisations such as the Royal National Institute of Blind People and the College of Optometrists. This was to

ensure there was strong multidisciplinary professional input and active patient and external stakeholder involvement. This approach ensured the alliance provides a whole sector voice for the profession and the greatest chance for patient-centred improvement.

A key aspect of the model is that the structure, direction and activities of an alliance are determined by the wishes of the members. This resulted in the UKOA developing a purpose distinct from the NOA as members consulted, debated and determined the direction of travel for the UKOA. This was not surprising given some key differences between ophthalmology and orthopaedics:

A key aspect of the model is that the structure, direction and activities of an alliance are determined by the wishes of the members.

- Ophthalmology has its own dedicated college, whereas orthopaedics does not.
- A large part of ophthalmology is outpatient work and care for chronic disease, whereas orthopaedics is primarily surgical in nature.
- There were already a number of ophthalmic quality standards and guidelines available.
- Ophthalmology outpatient services are increasingly delivered by non-medical clinical staff working in extended roles in community and secondary care settings. These allied professionals need to be included in the membership meetings.

Key learning – developing a specialty alliance model
✓ Leading the way in delivering better care and value through improved outcomes and productivity is best achieved through collaboration and not duplication.
✓ Governance should be shared, not dependent on a single trust.
✓ Someone has to drive the process in the establishment phase.
✓ Principles for developing an alliance need to be agreed to develop an implementation plan.
✓ Founder members should ensure the alliance is manageable in the establishment phase.
✓ Founder members should be representative of the specialty (not just all the largest services).
✓ It's good to replicate other models but tailor each sub-specialty alliance as appropriate.

11. Gathering evidence for your first alliance meeting

It is important not to underestimate the initial planning work. Even with the advantage of being able to replicate the NOA's methodologies, a very engaged and driven clinical lead and project manager were critical to the success of the UKOA.

Timescale and delivery will be dependent on who is driving the project and how much time can be dedicated to this work. The development of the UKOA is proof that with the right drive and commitment, quick replication is possible.

Developing an implementation plan, based on the principles used by the NOA, is encouraged. Replicating the NOA methodology was very effective for the UKOA.

11.1 Pre-planning communications

A draft communications and stakeholder plan is needed from the start. It will initially involve whoever is driving the project and their organisation's communications lead but once established this will need to be shared more widely among the member organisations.

Identifying very senior individuals who are willing to promote the alliance and be visible during the establishment phase will help external communications.

It will be helpful if the project lead has informal conversations with people identified as potential founder members. The formal invitation letter, setting out the purpose and aims of the alliance, can then be sent.

Consider who will sign the first invitation letter. It is advisable to ask a chief executive or medical director from a major unit to co-sign. It may be useful to include other co-signatories, for example from the professional colleges and the already-established specialty alliances.

The initial invitation should be sent to clinical leads, medical directors, CEOs, presidents, as appropriate to the organisation. Ensure they understand who is best to attend and that it should be a multidisciplinary team including, for instance, a clinical lead or senior consultant, manager and nurse. Executive representatives from each unit should also be included.

11.2 Draft terms of reference

To enable discussion with potential members and stakeholders as well as provide context for the first meeting, it is helpful to set out the proposed aims and benefits of the alliance. The UKOA agreed it would:

- Be a forum for regular liaison and discussion on efficiency, quality and other mutual areas of interest between key stakeholders for ophthalmic services.
- Bring together the expertise of clinical professionals, managers and trust leaders in commissioning, operational management and financial flows. This joint expertise would establish quality standards and best practice or efficiency pathways in consultation with the key professional bodies, providers and patient bodies covering care provided by any ophthalmic professional in any setting.
- Provide or support a web portal populated by NHS digital data and provider-supplied data, informed by GIRFT results, allowing benchmarking of processes and outcomes to drive up standards.
- Enable buddying and support to improve quality and efficiency between providers with good and less good performance in specific areas.
- Create a powerful voice which could negotiate locally and nationally for the benefit of ophthalmology commissioning and resourcing and champion the specialty generally.

It is helpful to set out the proposed aims and benefits of the alliance.

11.3 Developing a methodology for agreeing clinical standards

Following the NOA process, the UKOA leads decided to invest in developing a first set of standards to demonstrate the methodology and show potential for success. If this process is followed by future alliances, it is recommended that the project lead(s) identify potential areas of focus before the inaugural meeting. It is useful to work up a potential quality standard or a guideline and generate a list of other potential quality standards for the members to comment on.

It may be useful to consider standards:

- that do not exist but should.
- that people are already asking for.
- for key safety issues which should be in place.
- which would benefit from co-design with all stakeholders.
- for patients including co-developed patient education and support materials.

To help think this through, it may be useful to consider how the UKOA approached this stage of the process.

Before the first alliance meeting the UKOA project team assessed various options for evidence searches and literature reviews and found that the British Medical Journal Evidence team, who had conducted the work for the NOA, were best placed to support this work. Working with them, the team built on their NOA work to develop a template against which to analyse literature for our ophthalmic standards and a list of what those potential ophthalmic standards might be. Having worked through the planned methodology, two important areas were identified where there was felt to be a lack of standardisation and where the multi-professional nature of the alliance would be particularly suited to develop standards.

Two pilot topics were chosen: 'lazy eye' and intraocular lenses.

The two pilot topics chosen for quality standards were:

- Treatment of amblyopia ('lazy eye') in childhood. This was because it relates to all clinical professionals, not just ophthalmologists.
- Selection and insertion of intraocular lenses (IOLs) for cataract surgery. This was because it is the single biggest cause of surgical 'never' events.

Professional links and contacts were invaluable. A procurement efficiency lead from GIRFT was recruited, key national ophthalmology procurement leads were identified and NOA members suggested priorities for ophthalmology procurement which the NOA could support. In addition, information was shared about how the procurement landscape would change and how the alliance could influence that. This formed the basis of those involved in the subsequent procurement working group.

Key learning – preparing for your first alliance meeting
✓ Agree the communications plan at the outset.
✓ Canvass potential founder members informally.
✓ Don't underestimate the planning needed before any first alliance meeting.
✓ Agree the implementation plan.
✓ Be clear about proposed alliance aims and benefits to share with members.
✓ Do some groundwork to bring topics for discussion to the first meeting.
✓ It's good to replicate other models but tailor each sub-specialty alliance as appropriate.
✓ Remember this is collaboration so things may change once the members meet.

12. First alliance meeting

The key to a first successful meeting is getting the right people together.

For the UKOA, given the number of founder members, its geographical spread and the spirit of shared governance, it was important that the alliance met on neutral territory rather than becoming associated with any particular trust. Some key things to think about for the first meeting:

- A multidisciplinary team including a manager will add a rich mix to the discussions.
- Be flexible on date and location to get the right people there. Consider transport links and travelling time.

12.1 The agenda

The agenda should be planned and circulated in advance. The structure of the meeting will depend on numbers, location and interest. These suggestions are based on the UKOA experience:

- It is important that there is evidence of executive support. Asking one of the trusts' CEOs to make a welcome speech should be considered.
- Ensure that the intended purpose and aims for the alliance are shared with the members. Listen to feedback and adapt accordingly – they should be shaped by the members.
- Showcase the preparation work – in the UKOA's case this was the literature review leading to the suggested pilots and the groundwork for a procurement workstream.
- Show potential for efficiencies, for example cost savings, and demonstrate the potential for quality improvement that the alliance could achieve.
- Invite the experts you have been working with to be part of the day to share the learning.

The precedent for collaboration and shared governance should be established early and this is best achieved by seeking feedback from members. The UKOA meeting spent the afternoon in groups working on various questions. This work helped with planning the next steps for the alliance and ensured all members felt engaged in shaping the future work programme. Members discussed options for work which helped to develop a framework.

12.2 Workstreams

It is important to focus members on active work programmes that can be delivered. Asking members which standards they are interested in developing will ensure the workstreams will be relevant and more likely to be of interest.

There was significant consensus from UKOA members as to the priorities and they generated many topics of interest. These broadly fitted under three key workstream headings:

- data and costs.
- quality standards.
- services and staff.

To garner interest and enthusiasm, look for:

- quick wins.
- what people want.
- ways to make savings.
- who will do the work and how.

Members volunteered at the UKOA meeting or by email afterwards. Getting people to volunteer for particular pieces of work on the day of the meeting is a way of ensuring that these gain traction quickly.

All members should be encouraged to continually capture and share their work with the wider membership.

We have already indicated how important it is to have leads prepared to drive the momentum until the alliance is well established. Maintaining communication with members in the early stages to ensure there are sufficient volunteers to get involved in the various workgroups is key. It will be essential to get leads in place for each workgroup or this work will all fall to the initial alliance leads. Those taking a lead in the workgroups can get involved in recruiting to their group. Sharing member contact details will be important and encourage a flexible approach to meetings. All members should be encouraged to continually capture and share their work with the wider membership.

12.3 Updating the communication plan

During pre-planning a draft communications plan should be put in place and once the alliance begins to develop this should be updated.

The form of your alliance will dictate how you decide to communicate. For a national alliance (like the UKOA and the NOA), it will be important for members to agree how to communicate in their workgroups, how to share information, how to report progress and then how this progress can be shared between full membership meetings. The UKOA decided on quarterly meetings.

Channels used could include email, conference calls, Skype, website and newsletters.

The communication plan should be updated to include this information. It is also important that the alliance members share the learning within their own units as well as with other members.

Once the alliance is formed it will need an identity. Suggestions for a name were collected at the inaugural ophthalmology meeting and then members voted through an online survey.

The UKOA decided to develop a website and newsletter and to use email and conference calling for workgroups to communicate.

It is important to be clear that should the alliance proceed, at some time in the future costs will need to be covered through member fees (unless some other funding is forthcoming). Ensure that you are able to cover costs for at least one year so that members do not have make any financial commitment immediately.

Key learning from the first alliance meeting
✓ Have the meeting at an accessible location.
✓ Share the planning but let members change and decide things.
✓ Sign up workstream volunteers on the day or as soon as possible afterwards.
✓ Keep stakeholders involved.
✓ Don't duplicate work but implement existing standards.
✓ Give the alliance an identity as soon as possible.
✓ Agree how the members will communicate.

13. Ways of working together in an alliance

It is useful to consider different ways of bringing alliance members together to make the best use of time and resources.

Ideas generated by UKOA members included:

- Showcasing excellence and/or innovation to spread best practice quickly.
- Hosting workshops on key subjects bringing members together to get richer input.
- Holding relevant education seminars.
- Running joint clinician and manager workshops to better understand each other's roles and challenges.
- Producing and using information and outputs to generate documents and guidelines which can be shared with other members and published for wider use when appropriate.

14. Sustaining the alliance model

As well as the initial funding to get an alliance established, there needs to be consideration given to how it will be funded and managed longer term.

Members will need to agree where the alliance secretariat will be based once fully established.

How will the alliance be driven? A balance will need to be struck between having leads driving it and the need for shared governance (membership approach). These decisions should be captured in the terms of reference (TORs) so that all members are clear about the way in which the alliance will operate. Actions to be considered:

- Create a small board of leaders and decide who will host or oversee the alliance. Consider funding designated leads to ensure the alliance momentum is maintained.
- Decide what administrative support is needed. This should include communications, website and data management – this could all be one post.
- Draft and agree TORs to include the formal governance structure, representative leadership model and any liability issues.
- Decide on source(s) of funding and how they will be administered: will this be membership fees and/or other funding?
- Develop a business case, whatever the source of funding, as it is a tool to demonstrate outputs against planned activities and the value the alliance has added to the specialty.
- Ensure your aims and results meet any funding criteria.
- Agree how the alliance will support other specialties wanting to develop a similar model.

Key learning for alliance sustainability
✓ Use different ways to bring alliance members together.
✓ Run interesting workshops (free if possible) using member organisation facilities.
✓ Share excellence and innovation to spread best practice.
✓ Document and share workstream outputs.
✓ Be clear about the structure and leadership of the alliance.
✓ Don't underestimate costs, but have a lean secretariat.
✓ Decide where the alliance should be hosted.
✓ Capture the aims and plans in a business case so that the benefits can be evidenced later.

Annexe A

UKOA founder members:
Addenbrooke's Hospital, Cambridge University NHSFT
Bolton NHSFT
Bristol Eye Hospital (University Hospital Bristol NHSFT)
Gloucestershire Hospitals NHSFT
James Paget University Hospitals NHSFT
Leeds Teaching Hospitals NHST
Leicester Royal Infirmary (University Hospital of Leicester NHST)
Manchester Royal Eye Hospital (Central Manchester University Hospital NHSFT)
Moorfields Eye Hospital NHSFT
Newcastle Eye Centre, Royal Victoria Infirmary (Newcastle upon Tyne Hospitals NHSFT)
Norfolk and Norwich University Hospital NHSFT
Oxford Eye Hospital, John Radcliffe Hospital, Oxford University Hospitals NHSFT
Queen Elizabeth Hospital (University Hospitals Birmingham NHSFT)
Queen's Medical Centre, Nottingham University Hospitals NHST
Royal Cornwall Hospitals NHS Trust
Royal Glamorgan Hospital
St Paul's Eye Unit, Royal Liverpool and Broadgreen University Hospitals NHST
Sunderland Eye Infirmary, City Hospitals Sunderland NHSFT
United Lincolnshire Hospitals NHS Trust
University Hospital Southampton NHSFT
British and Irish Orthoptic Society
College of Optometrists
Ophthalmology clinical reference group (specialised commissioning)
Ophthalmology GIRFT
RCN Ophthalmic Nursing Forum
Royal College of Ophthalmologists
Royal National Institute of Blind People

Notes

UKOA
UK OPHTHALMOLOGY ALLIANCE

Email: uk.oa@nhs.net
Website: www.UK-OA.co.uk

www.networkedcaretoolkit.org.uk