



Dear Colleague,

Prioritisation of Patients Referred into Secondary Care Hospital Eye Departments

We are writing to advise you about a change in the way new and follow up patients referred into secondary care hospital eye departments will be prioritised on waiting lists. As you know, health boards currently prioritise new referrals from primary care to secondary care based on a target of a 'referral to treatment time (RTT)' with 95% of patients to be seen within 26 weeks. This target will remain, but will be supplemented by clinical categorisation and risk of harm for each individual patient.

Hospital eye departments will allocate health risk factor criteria of 1, 2 or 3, with 1 being a patient at the highest risk of sight loss/harm and 3 at lowest risk of sight loss/no harm. Each individual patient will also be allocated a target review date – a date by which the patient should be seen, based upon each patient's specific clinical circumstances. This target review date should be the main focus when communicating with patients about their appointments. This system will apply to all patients, both new and follow ups.

Patients will be seen in hospital eye departments in order of their clinical target date. If there is insufficient capacity to see all patients on their target date, the health risk criteria (1, 2 or 3) will be used to ensure those at highest risk of sight loss/harm are seen first.

Listed below are some potential frequently asked questions which may help when patients contact you:

- *What happens if the patient's individual target date is missed?*

If a patient contacts you to say they are overdue their target date, reassure the patient that they will be seen in priority order, based upon their risk of harm.

- *Should it be reported to the health board as well?*

Yes, it should be reported, using the practice NHS email address (due to patient identifiable details being used), to:

Aneurin Bevan UHB:

Julie Poole Julie.Poole@wales.nhs.uk

Abertawe Bro Morgannwg UHB (East)

Helen Robinson Helen.Robinson2@wales.nhs.uk

Abertawe Bro Morgannwg UHB (West)

Suzanne James Suzanne.James@wales.nhs.uk

Betsi Cadwalader UHB

Medwyn Jones Medwyn.Jones2@wales.nhs.uk

Cardiff and the Vale UHB

Tina Bayliss Tina.Bayliss@wales.nhs.uk

Cwm Taf UHB

Neil Cooper Neil.Cooper@wales.nhs.uk

Hywel Dda UHB

Gordon Wragg Gordon.P.Wragg@wales.nhs.uk

Powys THB

Andrew Powell Andrew.Powell2@wales.nhs.uk

- *How long will a patient wait once their category has been assigned?*

Both new and follow up patients will be seen by their allocated target date and in order of clinical priority. The target date will be clinically appropriate for each individual patient, whether that is to be seen 'immediately' or 'in 12 months time'. The RTT target of 95% of patients to be seen with 26 weeks will remain in place for new patients.

- *If I have any concerns about a missed appointment or an assigned risk category classification what shall I do?*

Contact the Health Board using the contact details provided above.

If you, or any members of your practice, have any further queries please contact your health board optometric adviser, regional optometric committee, Optometry Wales, or primary care health board team.

Yours sincerely,



Phil Jones
Chair Welsh Optometric
Committee



Andrew Riley
Chair Optometry Wales



Nik Sheen
Clinical Lead for Eye
Health Examination Wales

Performance Outcome Measures for Eye Care

New outcome-focused measures will be introduced with guidelines on clinical prioritisation based on the risk of harm associated with the patient's eye condition if the target appointment date is missed.

Background

Poor eye health is a common and growing issue. Currently nearly 107,000 people in Wales are living with sight loss. By 2020, this is predicted to increase by 22 per cent and double by 2050. Over 50% of sight loss can be prevented through early identification and intervention.

There has been concern for a number of years about the mismatch between demand and capacity in ophthalmology.

There are now a number of plans in place to deliver a sustainable service which meet patient need and expectations. The national Planned Care Programme established a Welsh Ophthalmic Planned Care Board and published a National Ophthalmic Implementation Plan in 2013. This contains 12 actions agreed by the clinical community to support the development of a sustainable service and improved patient experience.

The agreed actions will take time to implement and there is a need in the short term to ensure that patients who require ongoing follow-up treatment are seen and treated within clinically appropriate timescales.

The ophthalmology referral to treatment time (RTT) target has served the majority of new patients well; however, clinical evidence suggests approximately 10% of new patients are at risk of irreversible sight loss compared to, up to 90% of follow-up patients. For example, a patient with wet-Age Related Macular Degeneration (wAMD) requires additional review and care/treatment if they are to reach the optimum outcome. The subsequent pathway (follow-up appointment every 4-8 weeks) is not currently subject to a target or prioritised or recorded and reported on hospital waiting lists.

The Cabinet Secretary for Health and Social Services commissioned the establishment of an outcome focused measures task and finish group, chaired by Dr. Graham Shortland (Medical Director, Cardiff and Vale University Health Board). The group produced a report in 2017, containing a set of recommendations and new outcome measures.

The outcome measures account for both new and follow-up patients, based on clinical need and risk of harm. They are compliant with relevant guidance, including National Institute for Health and Care Excellence (NICE), Royal College of Ophthalmologists guidance and College of Optometrists guidance and the standards defined by the International Consortium for Health Outcome Measures (ICHOM). The outcome measures are being introduced via a phased approach, nationally, across Wales and will be applicable for all ophthalmic services - to be used throughout the whole patient pathway, for ophthalmologists, optometrists, orthoptists and all other staff involved in delivering patient pathways.

The new performance measure is:

- ***95% of R 1 patients are to be seen by their target date or within 25% in excess of their target date for care/treatment***

Three defined categories have been agreed to support the clinical prioritisation as follows:

- R1: Risk of irreversible harm or significant patient adverse outcome if patient target date is missed
- R2: Risk of reversible harm or adverse outcome if patient target date is missed
- R3: No risk of significant harm or adverse outcome

To embed the measures, health boards need to establish a system for the introduction of a **patient target date** for both new and follow-up appointments. This will involve:

- Patients having a maximum waiting time following referral and clinically indicated intervals for ongoing review throughout the pathway i.e. an individualised patient target date determined by clinical determination based on and in line with, national condition specific guidance or consensus.
- All patient pathways to be allocated a health risk code (as highlighted above) based on their risk of harm if their specified review date is delayed.
- 95% of R1 patient to be seen by their target date or within 25% in excess of their target date for care/treatment.

- Patient target dates to be sequenced in order within their clinical priority (R1, R2, R3) groups and clinical condition sub-category pathway groups (e.g. patients in the glaucoma pathway are in 'the glaucoma service queue'). Anyone missing their patient target date will be seen in priority sequence across all sub-categories, where the sequencing within any 'queue' is based on patient over-run expressed as a proportion of intended time to appointment.

The health risk code is related to the clinical risk, and not the expected time interval required for achievement of a target.

A R1 pathway review period can be any length, from weeks to months, depending on the condition and treatment requirements. The purpose of the priority code is to indicate the need to ensure that all R1 patients are prioritised for the booking of their next appointment within the timelines specified, thus reducing their risk of harm from their condition with any possible delay.

Within all categories, patients will have a clinically-evidenced patient target date, which will include their holistic need i.e. patient with an eye condition and co-morbidity could be categorised as R1. Their whole risk (health and social) and possibility of a significant patient adverse outcome is considered high not just their eye condition (e.g. risk of falls in the frail elderly). This in itself should not be seen as a method to create capacity.

The risk code will need to change if a patient's condition changes and will have to be reviewed at each assessment.

Urgent Vs Priority

As described above, patients will be given review dates based on clinical need. It is important that all clinicians understand the difference between priority and urgency. Patients at risk of irreversible sight loss are categorised as the highest priority and this is on the basis of the risk of harm associated with the patient's eye condition if the target appointment date is missed. For example, a glaucoma patient who has a review date of 6 weeks has the same R1 rating as a glaucoma patient who has a review date of 12 months and the same R1 rating as a wAMD patient who needs an anti VEGF injection in 4 weeks. Each of these patients will be prioritised according to the new outcome measures system and would be expected to be seen within 25% of their target date. In the example used, the glaucoma patients would be expected to

be seen at 6 weeks with a maximum delay of 1.5 weeks, 12 months with a maximum delay of 3 months and the wAMD patient would be expected to be seen at 4 weeks with a maximum delay of 1 week.

Urgency is how soon that patient should be seen given the current state and/or risk of progression of the condition. For example, if the review date goes beyond the 25% limit, these patients would be considered as urgent to be seen as they are priority 1 patients who have breached their clinically recommended timescale.

Priority is the risk of harm associated with the patient's eye condition if the target appointment date is missed.

Urgency is how soon that patient should be seen given the current state and/or risk of progression of the condition.

Please note that clinical conditions and categories will not be changed.

What does this mean for optometrists?

Below is a list of clinical conditions and how they will fit in with the new outcome measures clinical prioritisation categories. As you can see all glaucoma patients and the vast majority of medical retina patients will be classed as risk 1 patients. Within each health board there will currently be a significant number (on average 3000 to 4000 patients per health board) who, once the new targets are implemented, will have breached their clinical target date by more than 25%. Therefore, it will be urgent for health boards to ensure these patients are seen first and systems are put in place so that they are subsequently followed-up on time.

This is clinically significant in preventing this group of patients from suffering irreversible sight loss and receiving ongoing care.

The consequence of initially prioritising these patients is that this has been shown to have an impact on the waiting times for patients who fall into a lower clinical priority category (R2 and R3).

As you will see from the clinical conditions, the majority of cataract patients will fall into the R2 category. The evidence gathered has shown that waiting times for cataract assessment and surgery will rise by up to 30% whilst systems are brought into balance with capacity and demand. This does not mean that patients with conditions falling into R2 and R3

categories will not be seen, but that patients who have the potential for irreversible sight loss to be caused will be seen before them.

What can optometrists do in practice?

Communication

There is no doubt that this is the right thing to do for patients. The new outcome measures will ensure those patients at greatest risk of losing their sight are prioritised to be seen and followed up appropriately.

As mentioned previously, the current demand for ophthalmology services and the capacity to see all of these patients is not in balance, health boards have the responsibility to transform current services to achieve balance and to ensure patients who may be anxious about longer waiting times for their eye care appointments, understand the system.

The correct information is vital for patients and it is the responsibility of all primary care practitioners to give the appropriate information to them particularly at the point of referral and at subsequent appointments. Practitioners must ensure,

- Good understanding of the clinical guidelines and priorities
- All referrals are complete and contain all the relevant information required to assign patients to the appropriate prioritisation category
- Referrals are appropriate with realistic timescales based upon the patients expected clinical prioritisation. Patients are appropriately counselled if they are not in priority category 1 or 2 to ensure they understand that they will not come to irreversible harm due their appointment interval.
- Written information where available is provided to patients and if not, that patients are directed to information about their eye conditions. (See useful information section at the end of this document).

Some patients may be frustrated about the waiting time. It is vitally important for the success of the outcome measures that all stakeholders working in eye care understand the system, the need to prioritise patients at greatest risk and provide the correct information to patients with a lower clinical priority.

For example, and with reference to cataract referrals in particular; if a patient has a binocular visual acuity of 6/9 or better, it is important that

you ensure that they understand the risks associated with cataract surgery and confirm, following appropriate counselling and professional advice, that their symptoms warrant treatment. If they are referred with a binocular visual acuity of 6/9 or better and no other supporting detail on signs or symptoms that indicate their need for surgery, they may be categorised as risk 3. The practitioner should consider in these circumstances whether referral at this time would be in the patient's best interests. If there is supporting evidence that may change their prioritisation such as glare, visual discomfort, impaired contrast sensitivity, refractive imbalance, living or caring considerations, difficulty with particular tasks such as reading or driving etc. then these should be detailed clearly on the referral so that the patient can be prioritised appropriately. Unnecessary referrals will create greater stress on the system and will be counter-productive to producing a balanced sustainable service.

There will be challenges to overcome in the forthcoming months and undoubtedly there will be questions arising from the profession. Please find below a list of contacts for you to seek support regarding the implementation of the new outcome measures. Also attached below are appendices to help with your assessment and discussions with patients.

Questions about implementation and help to support both you as practitioners and your patients to navigate these changes will be very welcome.

Contact Details

Health Board Optometric Advisers and Primary Care Contacts

Aneurin Bevan UHB:

Mike George: Mike.George@wales.nhs.uk

Stephanie Campbell: Stephanie.Campbell@wales.nhs.uk

Primary Care Team: 01495 241293

Abertawe Bro Morgannwg UHB

Lyndsay Hewitt: Lyndsay.Hewitt@wales.nhs.uk

Primary Care Team: 01639 684500

Betsi Cadwalader UHB:

Paul Cottrell: pauldcottrell@sky.com

Cardiff and the Vale UHB:

David O'Sullivan: David.Osullivan2@wales.nhs.uk

Richard Holliday (Head of Dental and Optometry Services):

Richard.Holliday@wales.nhs.uk Tel: 029218 34517

Cwm Taf UHB

Timothy.Palmer@wales.nhs.uk

Allison Green: (Primary Care Development Manager):

allison.green@wales.nhs.co.uk Tel: 01685 3513410

Hywel Dda UHB

David O'Sullivan: david.osullivan@wales.nhs.uk

Mary Owens (Head of Dental and Optometry Services):

Mary.Owens@wales.nhs.uk Tel: 01267 239763

Powys THB

North- Paul Cottrell: pauldcottrell@sky.com

South- David Jenkins: david_r_jenkins@talk21.com

Public Health Wales optometric advisers

North- Helen Corson: Helen.Corson@wales.nhs.uk

South- Colm McAlinden: Colm.McAlinden@wales.nhs.uk

Eye Health Examination Wales clinical lead

Nik Sheen: SheenNJ@cardiff.ac.uk

Optometry Wales

Chief Executive- Sali Davis: salidavis@optometrywales.com

Chair- Andrew Riley: aroptom@gmail.com

Welsh Optometric Committee

Chair- Phil Jones: phil.jones1982@gmail.com

Annex 1: Clinical guidelines on clinical prioritisation

Summary overview of general prioritisation is outlined below. Detailed breakdown is provided in the table. However, clinical judgment may be used for individual cases at consultant discretion.

R 1: Patients may suffer serious irreversible harm from delays

Wet AMD (Not AMD in general)

Glaucoma

Diabetic Retinopathy

Paediatric patients with strabismus.

Paediatric surveillance patients with a raft of other conditions in which ocular pathology plays a part

Ocular cancers (new and previously treated)

Post-operative patients.

Ocular inflammation

Cataract patients with co-morbidity

Cataract patients with better eye visual acuity that may compromise safety

Others at consultant discretion

R2: Patients who may suffer reversible harm from delayed appointments

Most cataracts

Posterior capsular opacification

R3: Patients who may be inconvenienced or suffer mild/reversible consequences from delayed appointments

- Most adult squints
- Most dry eyes
- Most watery eyes
- Most chronic lid irritation
- Most adnexal cysts
- Most benign eyelid lesions

Clinical prioritisation specifications

Pathways	Condition	VA (BC) BEO	Presumed diagnosis	Factors/comments	Suggested grade
Cataract	Cataract	6/60	cataract	NA	R1
		6/18	cataract	Falls/ADL failing	R1
		6/18	cataract	Managing	R2
		<=6/12	cataract	driver in carer role	R2
		<=6/12	cataract	non driver	R2
		>6/12	cataract	NA	R3
		Posterior capsular opacification			
Glaucoma	Cataract and significant comorbidity		cataract plus		R1
	Glaucoma suspect normal IOP		GS		R1

Pathways	Condition	VA (BC) BEO	Presumed diagnosis	Factors/comments	Suggested grade
	Glaucoma suspect IOP ≥ 24		GS + OHT		R1
	OHT IOP ≥ 24		OHT		R1
	Glaucoma diagnosed and early		glaucoma		R1
	Glaucoma diagnosed and moderate		glaucoma		R1
	Glaucoma diagnosed and advanced		glaucoma		R1
	Recent / previous glaucoma surgery				R1
	Acute / acute-on-chronic angle closure		Angle Closure		R1
	Suspected wet AMD				R1
	wet AMD diagnosed				R1
	Suspected acute PVD		PVD		R1
Retina	Suspected retinal detachment		RD		R1
	Retinal detachment diagnosed		RD		R1
	Acute visual disturbance			sudden loss, new F&F, diplopia,	R1

Pathways	Condition	VA (BC) BEO	Presumed diagnosis	Factors/comments	Suggested grade
				amaurosis etc	
	Diabetic retinopathy	<6/9	Vit haem		R1
		<6/9	Maculopathy		R1
		>6/9	Background		R2
		Any defect	Background and above		R1
	Medical retina (other)	<6/9	BRVO		R1
		<6/9	CRVO		R1
		>6/9	Posterior uveitis		R1
	incidental fundus finding, malignancy not suspected				R2
Ocular plastics / Orbit	Oculoplastics/ orbit		SCC	rapid growth	R1
			Melanoma	rapid growth	R1
			BCC	slow growth	R2
			Other	slow growth	R3
			sudden		
	Epiphora mucocele/				

Pathways	Condition	VA (BC) BEO	Presumed diagnosis	Factors/comments	Suggested grade
Ocular plastics / Orbit	dacryocystitis				
	Epiphora mucocoele	chronic			R3
	Proptosis				R1
	Early TED	chronic			R2
	Cellulitis	sudden			R1
	Blepharospasm				R2
	Entropion				R1
	Ectropion				R2
	Ptosis, suspected aponeurosis disinsertion				R2
	Ptosis, suspected IIIrd nerve lesion				R1
	Lid lesion, malignancy not suspected				R3
	Lid lesion, malignancy suspected				R1
	Previously treated lid malignancy				R1
Neuroophthalmology CT/ MRI findings	Neurology consult with positive CT/ MRI findings				R1

Pathways	Condition	VA (BC) BEO	Presumed diagnosis	Factors/comments	Suggested grade
Neuroophthalmology	New swollen disc				R1
	Diagnosed IIH (BIH)				R1
	Migraine/ chronic headache				R3
	Cornea		Keratoconus	Gradual	R2
			FB/Trauma	Sudden	R1
			Chemical	Sudden	R1
			Perforation	Sudden	R1
			Marginal keratitis	Gradual	R1
			Keratitis - HSV/bacterial	Sudden	R1
			CL related keratitis	Sudden	R1
Motility	Previous graft and any acute symptoms				R1
	Dystrophy				R2
	Strabismus				
	Acute strabismus				R1

Pathways	Condition	VA (BC) BEO	Presumed diagnosis	Factors/comments	Suggested grade
	Chronic strabismus				R2
	Childhood squint/ amblyopia				R1
Other paediatric	Other paediatric (inc genetic review)		triage at consultant discretion		R1/2/3

Useful Links and Resources

Low Vision Service Wales: Phone: 01267 248793

EHEW manual: <http://www.eyecare.wales.nhs.uk/ehew>

All Wales cataract pathway: <http://www.eyecare.wales.nhs.uk/ehew>

Patient Leaflets: <https://www.college-optometrists.org/membership/free-patient-resources/patient-leaflets.html>

Patient information: <http://www.rnib.org.uk/eye-health-eye-conditions-z-eye-conditions/cataracts>

<https://www.rnib.org.uk/ourservices/rnibhelpline> 0303 123 9999

The All Wales Standards for communication and information for people with sensory loss:
<https://gov.wales/topics/health/publications/health/guidance/standards/?lang=en>