PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13 December 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Ophthalmology Deep Dive
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers – Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Carly Hill – Service Delivery Manager, Ophthalmology, Dermatology & Neurology

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit & Risk Assurance Committee considered the Ophthalmology Audit Tracker at the October 2022 meeting and the Chair requested a Deep Dive to include the recommendations included in the Ophthalmology Audit and Inspection Summary, with an outline of the challenges faced and how the team is progressing against them.

Cefndir / Background

The Committee will be aware that Ophthalmology services within the Hywel Dda University Health Board footprint are fragile having faced long-standing challenges, dating back several years. Such challenges are reflective of similar pressures across the UK.

Eye Care services in Wales have been the subject of several reviews, action plans and improvement initiatives which have failed to resolve the underlying capacity challenge within the service, both locally and nationally. Across Wales there has been concern over the ability of Ophthalmology services to manage the volume of new and follow-up patients requiring care.

Within Hywel Dda UHB the service has struggled to embed sustained improvement, primarily due to the deteriorating recruitment and retention situation within the Hospital-based Eye Service (HES), notably associated with a high number of consultant and nursing vacancies and heavy reliance on locum staff to support service continuity. Despite well-established clinical links between the HES and community-based optometry services, the deficit in senior clinical capacity within the service has previously limited the extent of integration between the HES and community optometrist pathways. The service has progressed in the development of Senior Clinical Leadership, strengthening the management team with a Consultant Ophthalmologist accepting the lead role.

The absence of effective clinical and administrative systems has also impacted on the integration of care pathways between the HES and community optometrist services.

To address this position Welsh Government (WG) introduced Eye Care Measures (ECMs) in 2018 with the aim of supporting the prioritisation of new and follow-up care equally, this included providing Health Boards with funding to develop sustainable solutions. The Audit & Risk Assurance Committee (ARAC) should note that the funding received is non-recurrent (to March 2023) and has been insufficient to address separate priorities in respect of medical retina pathways.

The Service undertook a number of actions to support and rationalise care during 2019, and in response to COVID-19 during 2020 and 2021, have further taken steps both at a Health Board level and regionally with Swansea Bay UHB through the ARCH process (A Regional Collaboration for Health: A unique collaboration between three strategic partners; Swansea Bay UHB, Hywel Dda UHB and Swansea University). These include:

- The development of a short-, medium- and long-term plan for recovery of cataract treatment.
- A regional business case for Glaucoma services, supported through the ARCH forum, including the development of Ophthalmic Treatment and Diagnostic Centres (ODTC's)
- Out-Patient Department (OPD) Transformational funding for the development of virtual diabetic retinopathy clinics.
- Increase in Nurse Injectors to support the delivery of wet age-related macular degeneration (wAMD) and release medical capacity to manage other eye conditions.
- Relocating the Rapid Access Casualty for Eyes into an outpatient footprint to maintain a green pathway for planned procedures through Tysul Eye Unit.
- Implementation of the Electronic Patient Record (OpenEyes) due to commence in October 2021, which will improve links between community optometric practices and the Hospital Eye service. This will enable a more robust model of community-based care to be developed including diagnostics undertaken in a community setting for virtual review by a consultant.

In addition to these actions, the service also has actions recommended following service reviews by the Delivery Unit, Health in Wales (HIW) and the Community Health Council (CHC), this report will provide an update on the progress against these specific actions.

Asesiad / Assessment

As reflected above, the service has been heavily engaged in the development of regional eye care pathways as part of the ARCH programme in recent years. This work is reflected in the progress outlined below in respect the recommendations offered the various external reviews listed, many of which overlap in their content & focus.

Report	Recommendations	Progress	Challenges
Delivery Unit – Focus on Ophthalmology	Lack of progress with Ophthalmic Diagnostic & Treatment Centre in Ceredigion	ODTC Contracts have been awarded to two providers: - • Carmarthenshire • Pembrokeshire	No expressions of interest received from providers in Ceredigion – Primary Care Optometry Team liaising with practices in this area.
	Concerns over the number of patients not reviewed within their target date	Risk stratification of Glaucoma patients complete. Review of Outpatient templates and Clinical job plans undertaken to maximise capacity	Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial

		Service micro-managing clinic booking to support both Eye Care Measures and delivery of Ministerial Measures	Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. Planned expansion of the Glaucoma service is expected to improve review response times through 2023.
	The Health Board should collate a single medium / long term ophthalmic plan incorporating costings of all service developments required to deliver sustainable ophthalmic services	Integrated Medium Term Plan (IMTP) developed and submitted along with an agreed and resourced medium-term plan for Cataract patients. Glaucoma plan developed and funded.	Further review of Glaucoma plan is scheduled due to lower than anticipated contractual interest from community-based optometrists. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model.
	Identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability fund to continue beyond April 2020	IMTP developed and submitted along regular updates to the Eye Care Collaborative Group on the progress of the transformational projects funded by the Sustainability fund. Sustainable monies have been invested in the Glaucoma and Cataract Plans, however, there still remain other areas of the service (age-related macular degeneration (AMD), Paediatrics, Vertical Radius (VR), plastics) that require investment.	Further review of Glaucoma plan is scheduled due to lower than anticipated contractual interest from community-based optometrists. Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. Pan-Wales clinical view that central investment in estate, infrastructure and workforce is required to develop a sustainable long- term Ophthalmology Service model.
	Implement its solutions to ophthalmology recruitment challenges, including treatment capacity urgently	Between September – November 2022 the service has successfully recruited two locum consultants and four speciality doctors. A second consultant with an interest in glaucoma has been awarded an honorary contract to continue to support this service.	Nationally recognised recruitment challenges for Ophthalmology continue. Clinical view that without central prioritised investment as outlined above, it will be difficult to attract appropriately qualified and skilled individuals who are able to be recruited into centres of excellence elsewhere across the UK.

	As part of the medium-long term plan development, the cataract service options require appraisal prior to the commencement of the next planning cycle, supported by clear, time-bound delivery plans	Regional medium term cataract plan agreed and resourced. Investment into Amman Valley has supported the repurpose of OPD for wAMD to allow the Day Surgery Unit (DSU) to undertake high volume cataract lists.	Recruitment of substantive workforce to support the delivery of plans continues to be a challenge. We have secured locum consultants, however, without national actions highlighted above, substantive recruitment will continue to be a challenge.
HIW – Thematic Review of Ophthalmology	Concerns around monitoring of follow-up patients	Risk stratification of glaucoma patients complete, including those on a follow-up pathway.	See on Symptom and Patient Initiated Follow-up is not considered a suitable pathway for Ophthalmology patients; therefore, improvements will be based around extended roles for optometrists which will be possible through contract reform. Planned expansion of the Glaucoma service is expected to improve review response times through 2023.
CHC – Eye care services in Wales	The Welsh Government & NHS to ensure digital communication moves forward at pace in all areas	Welsh Government centrally procured an Electronic Patient Record system 'OpenEyes'. Hywel Dda UHB agreed to pilot the Eye Casualty module whilst Swansea Bay UHB pilot the Glaucoma module.	Numerous delays to implementation due to nationwide technical issues. Issue outside direct control of Hywel Dda UHB.
	The Welsh Government & NHS needs to do more to reduce the current backlog of people waiting for appointments	Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Template and job plan redesign has been completed to ensure outpatient activity is protected whilst allowing emergency eye services to continue. Positive progress being achieved in delivery of Ministerial Measures requirements for the	Balancing the Ministerial Measures with the Eye Care Measures due to the backlog continues to be a challenge, however, through close micro-management of all available clinics and capacity we anticipate further improvement into 2023.

		52/104-week pathway measures for 2022/23.	
	The Welsh Government & NHS needs to make sure longer-term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales	Successful implementation of a data capture service for Diabetic Retinopathy, this frees up capacity in hospital settings to support the reduction of backlog. Investment into Amman Valley has supported the repurpose of OPD for wAMD to allow the DSU to undertake high volume Cataract lists. Sustainable monies have been invested in the Glaucoma and Cataract Plans, however, there still remains other areas of the service (AMD, Paediatrics, VR, plastics) that require investment. On Demand Training Centre (ODTC) Contracts have been awarded to two providers: - • Carmarthenshire • Pembrokeshire	Regional clinical workshop planned for early 2023 to consider opportunities for a long-term regional model. Pan-Wales clinical view that central investment in estate, infrastructure and workforce is required to develop a sustainable long- term Ophthalmology Service model.

It is evident from the above that significant progress has been achieved in the past few years to develop increasingly integrated eye care pathways, enabling care to be delivered more seamlessly across historical community, secondary care and regional boundaries. Significant investment has been committed to the development of medium-term plans for cataract surgery and glaucoma service models in particular.

Notwithstanding this progress, historical challenges relating to workforce development and demand/capacity imbalances remain which have been exacerbated by the legacy impact of the COVID-19 pandemic.

Further opportunities are anticipated with the advent of the nationally led electronic patient record ‘Open Eyes’ project which will improve the flow of clinical information between community and hospital-based clinicians.

The challenges highlighted by the external reviews referenced in this paper are common across all areas of Wales and there is a Pan-Wales clinical view for more regionally based solutions to address these challenges for the longer term. Via the regional ARCH programme in South West Wales, a regional clinical workshop is planned for 2023 to further consider opportunities for a long-term regional service model.

Argymhelliad / Recommendation

The committee is requested to take assurance from the progress achieved to address the recommendations highlighted by the external reviews referenced in this paper, notwithstanding

the continuing workforce development and demand/capacity challenges which remain across community and secondary care pathways. The Committee is also requested to note the regional and national discussions which continue which are expected to inform longer-term, regionally focussed plans for the delivery of eye care pathways across Wales.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.4 Assure that best practice and national guidelines are adopted in service development plans and pathways.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	180 – Risk Score 12 632 – Risk Score 16
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 3.1 Safe and Clinically Effective Care 7. Staff and Resources
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	WG National Planned Care Programme WG Eye Care Measures
Rhestr Termau: Glossary of Terms:	Reflected within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg:	Business Planning and Performance Assurance Committee Scheduled Care Quality & Governance Committee

Parties / Committees consulted prior to Audit and Risk Assurance Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Reflected in report
Ansawdd / Gofal Claf: Quality / Patient Care:	Reflected in report
Gweithlu: Workforce:	Reflected in report
Risg: Risk:	Reflected in report
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	Access times to follow-up care for glaucoma Access times to cataract surgery. Access times to Hospital Eye Services
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

Our Ref: SR/sep/SM-FOO20160307

7th March 2016

Mr Steve Moore
Chief Executive
Hywel Dda ULB
Ystwyth Building
Hafan Derwen
St Davids Park
Jobswell Road
Carmarthen SA31 3BB

Dear Steve

FOCUS ON OPHTHALMOLOGY: ASSURANCE REVIEW

The Delivery Unit (DU) has undertaken assurance reviews across the Health Board during February for the glaucoma and wet AMD pathways, and I am writing with the outcome of those reviews.

GLAUCOMA AND OHT PATHWAY

Carmarthen

The DU reviewed the above pathway in Carmarthen on 1 February 2016.

Two outstanding aspects were reviewed which relate to the completeness of the clinical referral from optometry to ophthalmology, and delays in follow up care.

Regarding referrals, the DU reviewed 20 new patient referrals from optometry to ophthalmology and found that 80% of them had been comprehensively completed. The Glaucoma Refinement Scheme is long established and overall the DU are satisfied with the quality of the clinical referral.

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In respect to the delays in follow up care, the DU reviewed 48 cases. Of these 18 patients (38%) had experienced a delay in their follow up appointment, with 56% of patients waiting longer than 50% of their intended target date. This represents a worsened position compared with the previous audit. Since that time there has been a change of consultant due to retirement, and a change in service delivery with ceasing of the nurse led glaucoma service. The lead glaucoma consultant has proposed a framework for future service delivery which is currently under consideration by the Health Board. Implementation of an agreed pathway will be crucial in preventing further backlogs in follow up care.

Ceredigion

The DU reviewed the above pathway in North Road on 29 February 2016. Concern has previously been expressed in regard to a complete lack of progress to introduce the ODTC service model and this concern remains current. The DU were previously advised that an ODTC would commence in November 2014 and that nurse practitioners were being developed for the role, however this has not happened and there is no ODTC. The DU cannot establish that there is an identified clinical lead for the glaucoma service within Ceredigion and as of this month, there are two consultant vacancies which are to be advertised through a collaborative campaign in March/April. There is a critical need to make substantive appointments of consultant ophthalmologists with appropriate subspecialist interests to complement those of the department and the clinical needs of the local population. The ODTC model works very well in many units across Wales and should be progressed within Ceredigion as a matter of importance, in order to reduce any clinical risk of patients with this condition.

Capacity has reduced significantly since last July due to physical congestion within the outpatient department, and the DU's most recent review shows that delays have increased compared to the previous audit. All of the new patients reviewed had not been seen in accordance with the clinically prioritised timescale. Referrals remain incomplete and letters are rarely copied to the optometrist following first outpatient appointment. These issues have been repeatedly fed back to the Health Board and should be addressed. In respect to follow up patients, 60% of patients reviewed are delayed beyond their target date, with half of those delayed longer than 75% of their intended target date. Patients are mostly seen by middle grade doctors with little apparent oversight by consultant ophthalmologists. This includes new patient assessment, commencement of treatment and discharge from the service.

WET AMD PATHWAY

Carmarthen

The Health Board has been able to progress plans to increase capacity through the Welsh Government funded pilot schemes. This has already seen the introduction of optometrist clinics for the review of stable wet AMD cases within their own practices and additional capacity created within Pembrokeshire for patient reviews and treatment. Plans are also in place for the introduction of capacity in South Ceredigion, for patient flows from Ammanford and Aberystwyth.

Cont…….

The DU reviewed 41 case notes of patients on the pathway at Amman Valley Hospital on 2 February 2016. The DU are pleased to advise the data shows that a considerable reduction in waiting times has been achieved since the previous audit, with most patients (85%) now being treated within 3 weeks of their referral by an optometrist, compared with 6 weeks at the previous audit. The national target is 2 weeks and the Health Board are achieving 66% within this timescale. There were no delays in follow up care recorded at the most recent DU audit which is commendable.

Given the recent introduction and ongoing phasing of the pilot schemes, the DU anticipates that the full capacity has not yet been reached and there is potential to completely eradicate delays in the system.

Ceredigion

The DU reviewed the above pathway on 29 February 2016. Capacity to undertake IVT has been problematic and the DU were advised that additional slots have recently been made available on the Thursday daycase list. The national target is 2 weeks from referral to first treatment for wet AMD and the recent review of new patients' shows considerable delays are being experienced. Of the cases reviewed performance was found to be highly variable with waiting times to first treatment ranging from 2 weeks to 13 weeks. The Health Board should give urgent attention to the front end of the pathway and ensure that sufficient capacity is made available for the assessment and treatment of patients referred with suspect wet AMD. To delay in this process may be placing patients at risk of irreversible sight loss. Follow up capacity appears to be sufficient, with 90% of patients seen within the clinical target date.

The Health Board are asked to review and consider the above findings and to respond at the earliest opportunity with definitive actions and timescales to address the shortfalls in service delivery.

Yours sincerely

Sue Rowe.

Sue Rowe
Assistant Director

Cc Mr Simon Dean, Deputy Chief Executive, NHS Wales, Welsh Government
Mr Andrew Carruthers, Delivery Programme Director, Welsh Government
Dr Barbara Ryan, Chief Optometric Adviser, Welsh Government
Ms Janet Davies, Specialist Advisor Quality & Safety, Welsh Government
Mr Mike Austin, National Clinical Lead for Focus on Ophthalmology
Mr Emrys Elias, Director, Delivery Unit

ALL WALES REVIEW OF PROGRESS TOWARDS DELIVERY OF EYE CARE MEASURES

HYWEL DDA UNIVERSITY HEALTH BOARD

May 2019

Review Lead: Elizabeth Beadle, Performance Improvement Manager
Assistant Director Lead: Philip Barry, Assistant Director – Scheduled Care
Delivery Unit Director Jeremy Griffith

EXECUTIVE SUMMARY

The NHS Delivery Unit (DU) undertook a review of progress across Wales towards delivery of the new eye care measures. Hywel Dda University Health Board was assessed against the review's four aims:

- To assess the impact of shadow reporting and readiness to undertake formal reporting;
- To assess progress to date, incorporating review of demand and capacity assessment, planning, infrastructure and implementation of plans;
- To assess how existing and short-term resources will be deployed to support sustainable service change and the sustainability of resourcing;
- To identify opportunities for improvement in local, regional and national infrastructure to support delivery of the eye care measures.

The Health Board supplied a detailed self-assessment and participated in interviews with the DU team. A strong commitment to improving eye care services was evident at all levels and the Health Board has key strengths with a proactive ophthalmology clinical lead and optometric adviser, plus optometric advisers at cluster level.

Progress has been made in developing a high-level vision for ophthalmic services, supported by some appraisal of cost. However, while staff identified a number of options for service developments, there is no single medium-long term costed ophthalmic plan. Nor is there currently programme support. Developing these key building blocks is fundamental to translating the commitment to improvement into action.

Demand and capacity assessment is limited to new cases and clarity is required on demand for follow up assessment and treatments to support the development of this plan.

The Health Board does not currently have an electronic patient record (EPR) having stopped its plans for local procurement pending the national EPR procurement exercise. This may limit ability to progress planned community service developments during the first half of 2019-20 and the Health Board will be able to increase the pace of its transformation work when the EPR is in place.

Plans for 2019-20 are being progressed for glaucoma and cataract services, however developments are supported in the main by short-term funding and ongoing funding commitment is not in place.

Workforce and physical infrastructure constraints present a challenge to progress; a planned recruitment drive requires supporting physical space development (e.g. increased theatre capacity) to attract and retain medical staff.

The Delivery Unit would like to extend thanks to Hywel Dda University Health Board's staff for their full participation in the review.

RECOMMENDATIONS

The Delivery Unit's recommendations to Hywel Dda University Health Board are listed below, in the order that they appear in this report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions.

Recommendation 1: The Health Board should undertake demand and capacity assessment of follow up pathways by sub speciality.

Recommendation 2: The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures. The Health Board committed to consider this recommendation at a meeting with the DU review team.

Recommendation 3: It is recommended that programme management resource be allocated to support the development and implementation of the long-term ophthalmic plan. The Health Board indicated that this would be its preferred approach.

Recommendation 4: The Health Board will need to identify sustainable monies to support permanent solutions for meeting ophthalmic demand to enable the developments supported by the Sustainability Fund to continue beyond April 2020.

Recommendation 5: The Health Board will wish to assure itself that there is an appropriate mechanism to connect monitoring to ophthalmic delivery plans with monitoring of progress with eye care measures delivery.

Recommendation 6: The Health Board needs to implement its **s**olutions to ophthalmology recruitment challenges, including treatment capacity urgently.

Recommendation 7: As part of the medium-long term plan development, the cataract service options require appraisal prior to the commencement of the next planning cycle, supported by a clear, time-bound delivery plan.

Recommendation 8: A revised plan/ funding mechanism for extension of W-AMD services should be developed to ensure there is sufficient capacity to meet this urgent demand.

INTRODUCTION

The incidence of eye health problems is increasing. The number of people living with sight loss in Wales is predicted to almost double by 2050, if treatment volumes, technology and other associated factors remain constant[1]. Despite developments in community and hospital based eye care services, these have not been able to keep pace with the growing demand.

Delivery of referral to treatment (RTT) targets has improved overall across Wales with a reduction in patients waiting over 36 weeks. However, fluctuation in breach numbers throughout the calendar year reflects ongoing sustainability challenges. Evidence suggests that there is insufficient follow up capacity in Ophthalmology with growing numbers of patients in the follow up cycle waiting beyond their allocated target treatment date. Many follow up patients are at equal or greater risk of sight loss as those newly referred.

Consequently, in 2018, new eye care measures were developed to ensure that follow up patients are given appropriate priority alongside new patients. The measures require every ophthalmic patient to be allocated a clinically-determined target date for next clinical event and a category of clinical priority based on the risk of irreversible adverse outcome associated with their clinical condition(s). These risk/priority categories are:

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

REVIEW PURPOSE AND METHODOLOGY

The Welsh Government commissioned the NHS Wales Delivery Unit (DU) to undertake a review with the following aims:

I. To assess the impact the shadow reporting has had on health boards and organisations' ability to report against the requirements of the new eye care measures officially from April 2019.

II. To assess health boards' progress towards delivery of ophthalmic services that balance the demand for both new and follow up/ ongoing care taking into account status of demand and capacity assessment, service planning, infrastructure, and progress with implementation.

III. To assess how existing resources will be re-deployed to maximise capacity and how additional short-term funding will be utilised to facilitate the required changes to the service model and infrastructure and whether sustainable funding sources have been identified.

IV. To identify opportunities for improvement in local, regional and national infrastructure to support delivery of the eye care measures.

The review comprised three phases, a review of the national context, self-assessment by health boards and visits to health boards to meet key clinical and managerial staff involved in the management of ophthalmic services in each Health Board.

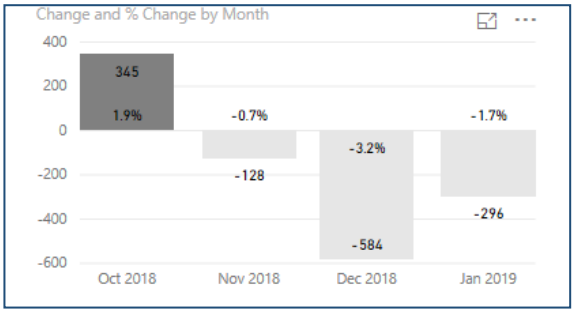
[1] Deloitte Access Economics, The economic impact of sight loss and blindness in the UK adult population, 2013. (RNIB, 2019)

This report sets out the DU's findings in relation to Hywel Dda University Health Board (the Health Board) following submission of a self-assessment during February 2019 and meetings with clinical and managerial staff undertaken during March and April 2019.

FINDINGS

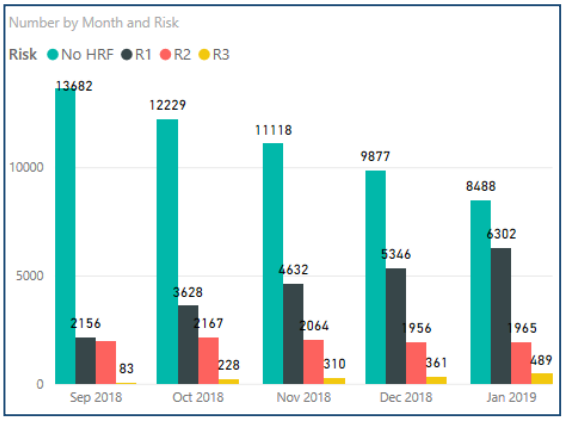
Reporting

The Health Board has completed monthly submissions during the shadow-reporting period and noted no impediments to ongoing reporting. The submissions provided to the DU identify that between September 2018 and January 2019 the following changes occurred:

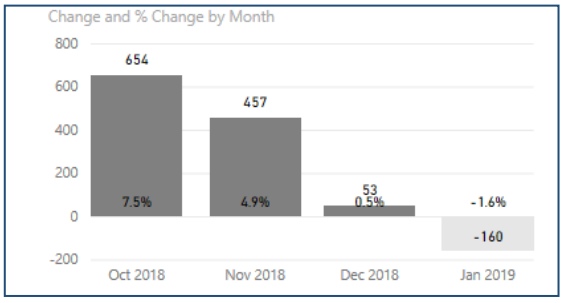


The total number of open pathways at month-end reduced by 663 (3.7%) to 17,244.

Within this, the new and follow up waiting lists reduced by 11% and 3% respectively between October 2018 and January 2019. The proportion of appointments offered to follow up patients was between 70 and 72% for the three months for which these data were available. This highlights the need for increased capacity for this cohort of patients.



The total number of patients with no identified risk status reduced from 13,682 to 8,488 (-38%) with a resultant reduction in the level of unknown risk of sight loss. During this period, the number of patients with a health risk factor status of 1 increased.



The total number of patients on pathways beyond target date increased by 11.6% to 9,682. Given the increase in volume of patients with R1 status, this may be partly attributable to having identified a proportion of patients requiring prioritisation for regular appointments.

The total number of patients without a target date increased by 42% to 536. However, these are all identified as new patients (without confirmed risk status).

Patient non-attendance rates were relatively stable for follow up patients, while non-attendance for new appointments increased, highlighting a potential opportunity to improve efficiency.

The Health Board has developed internal reporting which supplies the data for the eye care measures in both aggregated format and classified by new and follow up, which facilitates verification of data quality and performance management.

Progress with supporting infrastructure

Reduction in 36-week breaches for new patients and the volume of follow up pathways with no date booked highlights some positive progress. However, there remains a significant capacity gap for both new and follow up demand.

Demand and capacity assessment

The Health Board has assessed demand against capacity for new patients using derived demand calculations, however the demand for follow up assessments/ treatments is not clear. Further validation work is required to support assessment of follow up demand. Furthermore, follow up cases are not currently categorised by sub-speciality on the patient administration system, resulting in difficulty extracting sub-speciality level data. However, on the basis of information available, the health board has assessed that circa 50% of follow demand is for glaucoma patients and a key focus of the Health Board's short-term plans is on increasing capacity to manage glaucoma patients via community service development.

The lack of clarity on follow up demand is a significant limiting factor for the development of the Health Board's sustainable ophthalmic plan and may hamper the Health Board's ability to gain approval for required funding commitments.

Recommendation 1: The Health Board should undertake demand and capacity assessment of follow up pathways by sub speciality.

Planning and programme management

The Health Board has made considerable progress with regard to planning since the DU's review of ophthalmic diagnostic and treatment centres (ODTC) was undertaken in 2018. High-level commissioning intentions are set out in a document which assesses the requirements for sustainable ophthalmic care including associated initial capital and three-year revenue investment costs. The assessment reflects the Health Board's submission for monies from the Sustainability Fund. While there is a detailed plan for the implementation of actions supported by the Sustainability Fund, there is no single ophthalmic plan for the Health Board.

An eye care sustainability group has been instituted as an operational group to manage implementation of eye care service developments. This (monthly) group is chaired by the Health Board's Clinical Lead for Ophthalmology and reports to the Eye Care Collaborative Group. However, there is no dedicated programme resource currently allocated to the service and service developments are being progressed by the Service Manager, supported by the General Manager and Associate Director for Planned Care.

Recommendation 2: The Health Board should collate a single medium/long-term ophthalmic plan incorporating costing of all service developments required to deliver sustainable ophthalmic services covering all sub-specialities, supported by appropriate monitoring structures. The Health Board committed to consider this recommendation at a meeting with the DU review team.

Recommendation 3: It is recommended that programme management resource be allocated to support the development and implementation of the long-term ophthalmic plan. The Health Board indicated that this would be its preferred approach.

Funding

The Health Board made a positive commitment to improving ophthalmic services during 2018-19 with the appointment of four pathway coordinators (covering the key sub-speciality areas). However, several immediate service developments are heavily dependent upon sustainability funds and there is no current plan for ongoing funding beyond March 2020. Completion of a costed medium/long-term ophthalmic plan supported by robust assessment of demand and capacity is fundamental to making the case for ongoing funding to sustain improvements expected during 2019-20.

Recommendation 4: The Health Board will need to identify sustainable monies to support permanent solutions for meeting ophthalmic demand as a matter of urgency to enable the developments supported by Sustainability Fund monies to continue beyond April 2020.

Governance and management of risk

In addition to clear lines of reporting from the Eye Care Sustainability Group to the Eye Care Collaborative Group (which is chaired by the Executive Lead for Planned Care), the Health Board has a designated process for monitoring and escalation of issues for delivery of RTT to the executive team, with oversight from the Planned Care Board. However, although submissions are being made for the eye care measures, further consideration is required for the most appropriate reporting and monitoring mechanism. A separate group with a remit to monitor follow up not booked numbers exists, however its role is wider than ophthalmology.

There are regular reports to the Business and Performance Assurance Committee and Quality and Safety Committee (both sub-committees of the board) to ensure that the board is appraised of issues and risks. Ensuring that this appraisal of risk is connected to decision-making for sustainable service developments is required.

Risks and incidents are monitored at directorate level; the clinical lead is directly involved in reviewing incidents. Colleagues felt confident that clinical teams are comfortable with reporting incidents. Staff reported that there had been a never event approximately 12 months ago and whilst improvements had been made and were being progressed, indicated that they anticipated further incidents due to current constraints.

Recommendation 5: The Health Board will wish to be assured that there is an appropriate mechanism to connect monitoring of ophthalmic delivery plans with monitoring of progress of eye care measures compliance.

Regional service opportunities

There are no current plans to undertake regional work with Swansea Bay University Health Board under the ARCH collaboration, although there have been discussions about ophthalmic services, including a presentation on the Health Board's cataract service plans. Joint service developments present an opportunity to maximise the use of ophthalmic resource, for example through joint staff appointments or network arrangements, which would support maintenance of services for sub-specialities with significant staff vacancies. This represents a missed opportunity for the Health Board, which may limit its scope to deliver sustainable services for all sub-speciality areas, particularly for specialist areas that do not have significant volumes of patients. Equally, regional service development may offer economies of scale.

Progress with service development

Building on the strength of optometric advisers at cluster level, the Health Board has a real opportunity to progress its community glaucoma services and enhanced cataract referral process. However, the Health Board does not have an electronic patient record (EPR) and has some limitations on the ability to realise fully the benefits of community services pending the completion of national EPR procurement.

Current hospital staff capacity and physical space limitations present a significant challenge to progress. A recruitment plan was described, however colleagues highlighted concern that resolution of theatre capacity limitations, in particular is necessary to attract and retain suitable medical staff.

Recommendation 6: The Health Board needs to implement its **s**olutions to ophthalmology recruitment challenges, including treatment capacity urgently.

Cataract service model

The Health Board has made positive progress with the direct to listing cataract model. Enhanced referral has been piloted with one optometric practice. The associated processes and paperwork have been refined and further pilots are planned. Once rolled out to all practices, this would significantly reduce the burden of new outpatient appointments for cataracts, releasing time for other activity.

The Health Board has identified that there will be a deficit of 1648 cataract treatments during 2019-20, in part attributed to medical team vacancies and limitations on cataract operating facilities. Consequently, a short-term plan to outsource treatments has been approved, pending longer-term developments.

Health Board colleagues described a number of potential options to increase cataract treatment activity, including increasing the available operating facilities and options to increase staffing. A clear plan costed service model appraisal/business case was not available for the development of cataract treatment capacity. Without a clear decision and plan to

implement changes to deliver treatment capacity, the Health Board will continue to hold deficits and is likely to continue to be reliant on outsourcing to deliver cataract treatments within requisite timescales to all patients.

Recommendation 6: As part of the medium-long term plan development, the cataract service options require full appraisal prior to the commencement of the next planning cycle supported by a clear, time-bound delivery plan.

Glaucoma service model

Incorporating the assumption that 50% of follow up patients are glaucoma patients/ocular hypotensives, the Health Board has planned to develop glaucoma ODTC services in optometric practices. Supported by Sustainability Fund monies, a procurement exercise has commenced to recruit optometric practices. The Health Board describes the optometric community as very engaged and is therefore confident of success in recruiting practices. The Health Board is tendering for 5000 to 6000 units of activity and expects a short lead-in time following completion of the tender as a number of optometrists have already received appropriate training (enhanced certification) and a clinical protocol has been developed. The first cohort of patients is anticipated to be reviewed by optometric practices during late summer 2019. One the EPR is available the Health Board will review the model and seek to extend it further.

The DU review team was informed that the aspiration is for all glaucoma patients to be reviewed twice annually in the community to manage the risk of potential sight loss. It was not clear from discussions with the Health Board how the new service model would be sustainably supported.

Wet age-related macular degeneration (W-AMD) service model

Since the DU's ODTC review was undertaken in 2018, the service reports improvement in compliance with the required referral to initial treatment time of 14 days. The Health Board highlighted that the allocation of monies from the Sustainability Fund was lower than the bid and therefore a funding mechanism is not currently in place for further W-AMD developments. The service described the intention to explore the potential to expand the number of non-medical injectors.

Recommendation 7: A revised plan/ funding mechanism for extension of W-AMD services should be developed to ensure there is sufficient capacity to meet this urgent demand.

CONCLUSIONS

There is evident commitment to service development within the ophthalmology and wider community ophthalmic services and the Health Board has made progress in developing its vision for service development and progressing changes to cataract and glaucoma services. However current constraints (financial, staffing, and information) along with the lack of overarching ophthalmic service development plan and supporting programme structure present a significant challenge to increasing the pace of progress and ensuring sustainability.

NEXT STEPS

Subject to progress, consideration will be given to the need to undertake a further assessment of implementation of plans to deliver the requirements of the eye care measures.

APPENDICES

Appendix 1 – Terms of reference

A copy of the signed terms of reference for this review is appended.

Eye Care Measures Review Signed ToR H

Appendix 2 – Acknowledgements

The Delivery Unit would like to thank the staff at Hywel Dda University Health Board for their full collaboration and support with this review.

Appendix 3 – Bibliography/references

Data Standards Change Notice (DSCN 2018/07)
Deloitte Access Economics, The economic impact of sight loss and blindness in the UK adult population, 2013. (RNIB, 2019)
Together for Health: Eye Health Care, Delivery Plan for Wales, 2013 – 2018

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ophthalmology Services

Thematic Report
2015-16

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

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To provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

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- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
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1. Foreword

In the 2015/16 Healthcare Inspectorate Wales (HIW) Operational Plan, HIW proposed to undertake a thematic review relating to ophthalmology. This was due to the concerns being highlighted across Wales relating to the waiting times being experienced by ophthalmology patients and the potential for harm that could occur as a result.

The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing services, and to define the care and support required by patients. Due to the risks associated with any delay in treatment for patients with 'wet' Age Related Macular Degeneration (AMD), it was decided that the review would be based around the 'wet' AMD pathway.

The aim of the review was to assess how effectively health boards have been utilising service integration as a means of making the best use of the breadth of expertise and resources available.

In 2014-15 Health Boards in Wales were given £16 million to fund AMD services. The National Ophthalmic Implementation Plan[1] was also launched by Welsh Government in January 2015. The purpose of the National Ophthalmic Implementation Plan is '***to improve patient experience and deliver sustainable services***'. The plan requires health boards to understand and measure demand and capacity for the main subspecialties in ophthalmology. The purpose of the national planned care programme is to provide "sustainable" planned care services, and to optimise the patient experience of using planned care services.

This thematic report brings together and examines our findings following the fieldwork undertaken. It aims to identify common issues being experienced across Wales as well as some of the initiatives being introduced in areas in attempt to improve services. Recommendations are included for health boards and Welsh Government.

[1] http://gov.wales/docs/dhss/publications/150130opthamicimplementen.pdf

‘Wet’ Age-related Macular Degeneration (AMD)

‘Wet’ Age-related Macular Degeneration (AMD) is the leading cause of irreversible blindness in Wales[2]. The condition presents with a sudden disturbance of central vision and may progress rapidly. It is characterised by the growth of abnormal, leaky blood vessels under the central part of the retina (known as the macula). The most aggressive forms cause irreversible damage within weeks. The early diagnosis, treatment and timely monitoring of ‘wet’ AMD is essential for reducing the risk of severe vision loss.

The condition occurs in people over the age of 50.

There is no cure for ’wet’ AMD. The aim of treatment is to stop leakage, reduce the risk of bleeding and preserve remaining vision. Treatment involves injecting medicine directly into the anaesthetised eye, whilst management also involves the rehabilitation of vision with low vision aids such as magnifiers or adaptations to the home to maintain independence.

[2] http://brief.euretina.org/research/amd-continues-to-be-the-leading-cause-of-vision-loss-in-england-and-wales

2. Executive summary

HIW completed a thematic review relating to ophthalmology, focusing on 'wet' AMD services. The review set out to look across the boundaries of primary and secondary care to examine how providers were delivering and developing the care and support required by patients. The aim of the review was to assess how effectively health boards have been utilising service integration as a means of making the best use of the breadth of expertise and resources available.

Our review consisted of two phases. Phase one involved interviews with senior representatives from all health boards. Phase two involved additional interviews with operational staff from three selected health board areas namely Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board and Hywel Dda University Health Board.

The main issue for eye care services across Wales is insufficient capacity in secondary care to meet current demands. This issue is not restricted to macular degeneration services.

We found fragility of 'wet' AMD services is a major risk, due to the reliance on individual medical and administrative staff. When key personnel are absent parts of the care pathway cease working effectively. This generates backlogs which are difficult to clear. The Royal College of Ophthalmologists'[3] two-week referral to treatment target (RTT) is quickly breached with potential for avoidable harm to patients.

There appears to be a clear understanding across all health boards that further development of services is required to fully utilise available resources, including non-medical staff, to strengthen infrastructure and sustainability of eye care services. A greater proportion of consultant time should be focussed on the tasks that only they can do.

We saw several new initiatives across Wales relating to delivery of 'wet' AMD services. These included the introduction of non-medical injectors, and the development of Welsh Government (WG) funded pilot services within community based sites. These pilots were designed to increase capacity and provide more integrated services between primary and secondary care. However, progress in development and delivery of these initiatives has not been consistent across health boards.

Our review highlights the increasing demand on secondary care services. We saw some excellent examples of co-operation between primary and secondary care. In one remote area within Hywel Dda University Health Board, a system has been introduced involving optometrists undertaking regular assessments for stable patients, reducing the need for elderly patients to travel long distances and easing the pressure on hospital services.

[3] The Royal College of Ophthalmologists champions excellence in the practice of ophthalmology.

Also, within an optometry practice in Newport city centre, a service has been introduced involving optometrists providing a referral refinement service which has greatly enhanced the ability of consultants in secondary care to accurately triage suspected 'wet' AMD referrals. The success of these initiatives is reliant upon good communication and co-operation between staff in primary and secondary care.

We heard that poor working relationships between primary and secondary care in some health board areas have hindered efforts to improve joint working.

The Welsh Government has taken steps to address these issues, by requiring all health boards to establish an Eye Care Group and appoint an optometric advisor.

Eye Care Groups are chaired by a member of the health board executive team. Membership of the group includes clinical and managerial leads from primary and secondary care, the optometric advisor, the Community Health Council and local third sector organisations. They aim to provide a forum to discuss issues of concern, develop lines of communication, build trust and foster joint working initiatives. The role of the optometric advisor is to work with colleagues in secondary care to improve working relationships and facilitate initiatives to deliver more joined up services.

We were informed by primary and secondary care staff that relationships between these two sectors have improved. However, more work is required in many areas, for example better utilisation of Eye Care groups.

We heard concerns from health board staff about the lack of investment in the development of eye care services over the past few years. We were told that investment in services has not kept pace with the growing demand. As a result there is now a significant deficit in the capacity to deliver safe and timely care.

Recruitment and retention of medical and non-medical staff is an issue and a contributory factor to the fragility of services. We heard that more attention to workforce planning is needed. In particular, better succession planning is required for all staff groups. More thought should be given to providing opportunities for career development among non-medical staff mitigating the risk of overreliance on key members of staff.

We were told that health boards demonstrated little understanding of capacity and demand. The patient management systems used to actively capture data are inadequate; it is very difficult to extract useful information from them. Much of the subspecialty data presented to the Welsh Government National Planned Care Board[4] has been gathered by labour intensive processes which are unsustainable. There is limited data publically available specifically in relation to 'wet' AMD patients in Wales. Information available relates to numbers of overall opthalmology patients.

[4] Ophthalmology planned care board was one of four (others are orthopaedics, Ear Nose and Throat and Urology) established as part of the Welsh Government planned care programme. This programme has been set up to support health boards to improve patient experience by sharing good practice and creating sustainable pathways of care.

We conducted a range of interviews during the course of our review, receiving significant anecdotal contributions from a variety of stakeholders. Whilst clear themes emerged from the view expressed, we were disappointed at the availability of quantitative and performance data, to further explore and qualify these views. We have recommended that improvements are made to information management systems within health boards.

Health boards need better information about the demand capacity gap to enable informed workforce planning decisions. The allocation of resources should be dictated by patient need.

We found deficiencies in the ability to share clinical information across multiple sites. For example, in some areas it was reported that it was not possible to share clinical images between sites despite digital images being captured with the same brand of optical coherence tomography (OCT)[5] camera in two clinics. This causes difficulty for staff, results in duplication and impacts upon continuity of care, as well as the efficiency of the service. We heard concerns that the introduction of additional community based sites without the correct infrastructure may exacerbate this issue.

Health Boards should encourage clinical leadership, decide on priorities for development and ensure a unified approach. For example, the main imaging system should be consistent and networked across the health board to facilitate efficient service delivery.

The unsuitability of environments in secondary care from which services are being delivered from was consistently reported to us as an issue. We were told that the lack of space and facilities are limiting capacity to meet demands on the service. For example, a lack of clean room facilities to perform intravitreal injections was limiting the amount of injections that could be performed.

We heard that public awareness is an issue that requires more attention. Too often 'wet' AMD is first detected during a routine eye test, by which time vision may already be poor. The public need to be reminded of the importance of having their eyes tested regularly. They should look out for changes in central vision especially distortion, reporting any concerns promptly to an EHEW (Eye Health Examination Wales) accredited optometrist. There is a need for greater clarity around the services available for people with eye problems. In particular, the fact that EHEW examinations are free for people living in Wales who develop an acute eye problem and that there is no obligation to buy glasses.

Overall, our review highlighted a lack of leadership and focussed strategic planning within health boards to develop ophthalmic services. Most services have insufficient core capacity to meet demand. Progress has been made in some areas to strengthen service capacity and improve efficiency. Further focus is required to ensure that all health boards establish more sustainable, patient centred services.

[5] is a non-invasive imaging test that uses light waves to take cross-section pictures of your retina, the light-sensitive tissue lining the back of the eye

3. What we did

In 2015-16 HIW committed to undertake a thematic review of ophthalmic services across Wales. Due to the risks associated with any delay in treatment for patients with 'wet' AMD, it was decided that the review would be based around the 'wet' AMD pathway

We gathered information about ongoing work relating to delivery of eye care services. This highlighted that there had been a concerted effort to address issues in relation to demand, capacity, activity and backlogs. This work included the introduction of the National Ophthalmic Implementation Plan in 2015, as well as other initiatives which have been introduced within individual health boards. For example, the Clinical Prioritisation Project aimed at ensuring patients are seen in accordance with clinical need as opposed to a generic waiting time target (Referral to Treatment Time (RTT)).

Despite this work we learnt that patient waiting times within secondary care remain a significant issue.

As part of our review we considered progress that had been made in relation to the relevant sections of the National Ophthalmic implementation Plan across Wales. We looked at other initiatives introduced within health boards, to gauge whether care pathways are patient centred and efficient. Additionally, we reviewed how effectively health boards have utilised service integration to make the best use of the variety of expertise and resources available.

To assist our review we approached the Royal College of Ophthalmologists and College of Optometrists [6] to seek relevant expertise for our review team.

A stakeholder reference group was established as part of the review which included membership from Optometry Wales [7], Community Health Council (CHC), RNIB Cymru[8], General Optical Council[9] and the Welsh Government. This group was set up to ensure that relevant organisations were kept suitably informed with the plans and progress for the review, as well as to provide guidance and scrutiny to our review where necessary.

[6] The College of Optometrists is the professional, scientific and examining body for optometry in the UK, working for the public benefit

[7] Optometry Wales is the professional umbrella organisation representing all community optometrists, dispensing opticians and optometric practices across Wales.

[8] RNIB Cymru is Wales' largest sight loss charity, which provides a wide range of services and support to blind and partially sighted people across Wales, as well as campaigning for service improvements and to prevent avoidable sight loss.

[9] The GOC are an organisation which regulates optical professionals in the United Kingdom. They set standards, hold a register, quality assure education and investigate complaints.

The review was undertaken in two phases:

- Phase one consisted of discussions with senior representatives from each of the health boards with the overall purpose of building up an all-Wales picture of what the current pathway looked like in each health board area. This phase helped to identify the main 'bottleneck' issues and understand what service development plans were being produced in an attempt to improve services.
- Phase two consisted of additional, more specific interviews in three selected health board areas. These interviews were with those staff directly responsible for the delivery and coordination of the care and treatment to patients. The areas selected for phase two interviews were Betsi Cadwaladr UHB, Cardiff and Vale UHB and Hywel Dda UHB.

As part of phase two, we also held group discussion sessions with primary care optometrists to ensure that we could consider their views and opinions on the pathway.

We also worked with the Board of Community Health Councils (CHC) during our review. The CHC's undertook a National Ophthalmology Patient Experience Review during 2016 and the CHC's work was shared with us to allow for patient views to be incorporated into our report findings and recommendations.

We conducted a range of interviews during the course of our review, receiving significant anecdotal contributions from a variety of stakeholders. Whilst clear themes emerged from the views expressed, we were disappointed at the availability of quantitative and performance data, to further explore and qualify these views.

4. What we found

Patient Referrals

Referral Process

In Wales the vast majority of 'wet' AMD referrals are initiated by optometrists working in primary care. The current process is that 'urgent' referrals are faxed through to the relevant clinic via a rapid access form. Once the referral is received the patient will undergo further assessment in secondary care which will involve an Optical Coherence Tomography (OCT) scan and a fluorescein angiogram[10]. This information is then reviewed by a Consultant Ophthalmologist to establish the diagnosis. If the presence of 'wet' AMD is confirmed, the patient will be offered treatment, which involves medication being injected into the eye.

The Royal College of Ophthalmologist recommends that treatment for the 'wet' AMD should commence within two weeks of the initial referral. Once treatment has started the patient needs to be monitored at varying intervals dependent on the treatment plan and drug chosen by the consultant. Recent changes to the Ranibizumab (Lucentis)[11] licence allow for longer follow-up intervals in selected cases. If patients are not seen within the clinically recommended timescales, there is an increased risk of poor visual outcome, including legal blindness.

We were told by optometrists that in general the 'emergency' or 'urgent' referral system for patients works well. It was felt by the optometrists we spoke with that the majority of cases referred as 'wet' AMD suspects are seen quickly in secondary care for an initial assessment. However, problems do sometimes occur. For example, occasions where 'wet' AMD patients have suffered harm as a result of there being delays in them being seen within secondary care.

We found that part of the problem for the delay in patients being seen by secondary care related to the method in which referrals were sent through. We were told by optometrists that there is currently no way of them knowing whether referrals have been received and read by secondary care once they are sent. Therefore, once a referral is faxed it is typically followed up with a telephone call by the optometrist's receptionist to the relevant clinic to establish whether it has been received and to confirm an appointment has been made for the patient. However, this manual process of telephoning eye clinics is both time-consuming and inefficient, in many cases taking multiple phone call attempts.

[10] a fluorescent dye is injected into your arm. Pictures are taken as the dye passes through the blood vessels in your eye. This makes it possible to see leaking blood vessels, which occur in a severe, rapidly progressive type of AMD.

[11] a prescription medicine for the treatment of patients with wet age-related macular degeneration (AMD), macular edema following retinal vein occlusion (RVO), and diabetic macular edema (DME).

We also found issues in relation to general or standard referrals (non-urgent) which are being sent through to secondary care via letter. We were told that some of these referrals are being dealt with extremely slowly and again there is no way of knowing whether the letters are being received or read. For example, when cataract patients are being referred onto secondary care currently there is no way of logging the referral. We heard of some patients who have returned to the referring optometrist over a year later yet to be seen in secondary care. This is clearly not acceptable, given that the RTT target for cataract patients is 26 weeks.

The introduction of electronic patient referrals would be of benefit. As well as being a more efficient process, it should safeguard against the risk of referrals being missed or duplicated. There are plans for NHS Informatics Service (NWIS)[12] to progress this area. However, as part of our review we were informed that the implementation of electronic referrals is going to be delayed until there has been further progress made in relation to the introduction of electronic patient records.

There has been an electronic patient referral trial undertaken in all health board areas which was initiated by the Welsh Government through NWIS. There were eight optometric practices selected to take part in the trial. Each selected practice has had to contribute data and attend regular meetings with NWIS relating to the functionality of the electronic referral trial process. We hope that this pilot aids with the implementation of electronic patient referrals across Wales.

The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. Given the emotional impact of potential sight-threatening disease, it is extremely important primary care staff ensure patients are provided with adequate information about their eye condition and the treatment pathway they are being referred onto.

Quality of Referrals

We found that the quality of the referrals sent to secondary care from optometrists is variable. In some cases, lack of relevant detail makes accurate triage difficult. Inappropriate use of the rapid access pathway including for other macular diseases exacerbates delays for true 'wet' AMD cases. This is particularly difficult for health boards in trying to provide one-stop services where diagnostic investigations and treatment are offered at the first visit. Despite some reports of improvement in the quality of referrals it was still felt to be an issue throughout Wales. In one are within Hywel Dda UHB for instance it was reported to us that around 50% of referrals being sent are not 'wet' AMD. These referrals have to be screened out at the first appointment following review.

[12] NWIS are the national organisation delivering technology and digital services for modern patient care in Wales.

In attempting to understand the reasons for these referrals ultimately deemed inappropriate by the consultant, our discussions with optometrists revealed that when the symptoms being displayed by the patient are indicative of 'wet' AMD (in the absence of an in-house OCT and relevant training/qualifications), they are clinically bound to refer the patient onto secondary care to investigate the presence or absence of the relevant symptoms.

The optometrists felt fully justified in this approach to prevent avoidable vision loss. If they are uncertain of the diagnosis their clinical priority is to safeguard the patient. Some cases of 'wet' AMD may report typical symptoms in the absence of obvious clinical signs. In these cases an OCT scan is very helpful.

Most optometrists in primary care do not have access to an OCT scanner. Those with a scanner felt that it helped them to reach conclusion more quickly in relation to patient symptoms, and allowed for a more informed decision about which patients need to be referred onto the rapid access pathway. A suggestion put forward to us was to amend the patient pathway to allow optometrists without OCT scanners to make a 'sideways referral' to another optometrist with access to a scanner. It was felt that this approach could reduce the demand on secondary care with fewer OCT scans needed within secondary care, and a reduction in the number of inappropriate and false positive referrals.

An 'acute macula' referral refinement system was recently introduced in Aneurin Bevan University Health Board. All suspected cases are referred directly to an optometry practice located in Newport City Centre. The practice is equipped with an OCT scanner linked to secondary care. Patients are offered an assessment within two days. The logMAR[13] visual acuity is measured and an OCT scan performed. An electronic referral is generated in every case for triage by a retina consultant within 24 hours. A letter is sent to the patient, copied to the referral refinement centre, the originating optometrist and general practitioner. The patient also receives an information leaflet explaining their condition and any proposed investigation/treatment. During the first six weeks of this scheme (October-November 2016) 36% of 'acute macula' referrals assessed did not require an appointment in secondary care, 31% went onto attend the rapid access clinic and the remainder were directed into a more appropriate care pathway in the eye clinic. The mean time from originating referral to first treatment for 'wet' AMD suspects reduced from 34.7 days to 15.9 days, with no patient waiting longer than 28 days to start treatment.

[13] A LogMAR chart comprises rows of letters and is used by optometrists, ophthalmologists and vision scientists to estimate visual acuity.

The introduction of this pathway required clarity on training, funding and equipment for optometrists taking on the role. The health board needed to be assured that optometrists had the required knowledge and experience to acquire images of diagnostic quality. An electronic system was created to transfer referral information from the refinement centre to the triaging consultant. To avoid unnecessary delays, several optometrists in the refinement centre were trained to use the OCT scanner and there is a system for cross cover between retina consultants triaging referrals within secondary care.

Health boards should consider introducing methods to address the number of inappropriate or false positive referrals received via the rapid access pathway. Consideration should also be given to the availability of scheduling training events/ seminars aimed at raising awareness of optometrists and other relevant staff.

Communication Following Referral

As highlighted above, there appears to be a lack of communication from secondary care once referrals have been sent. We learnt that this was an issue for all eye care referrals; however AMD services (rapid access) were felt to be particularly poor. In most cases, optometrists are only being updated on the action taken following the referral when the individual patient returns to the practice to see them again. This means that the optometrist is reliant on the patients' understanding on what they have been told about their diagnosis as well as any subsequent treatment that has taken place. Consideration needs to be given to methods of ensuring that referring optometrists are provided with updates on any subsequent diagnosis and treatment received by their patients.

Whilst there are legal requirements which state that letters have to be sent from secondary care to the patients GP in relation to their diagnosis and any treatment received. This information is not consistently being sent to the referring optometrist to update them. The Welsh Government's Welsh Health Circular[14] previously detailed that patient consent is required for this information to be provided to the optometrist, even if it was the optometrist who made the initial referral. However, the Caldicott review published in 2013 created an additional principle "The duty to share information can be as important as the duty to protect patient confidentiality". The review stated that "for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual".

It appears that there is a lack of feedback to optometrists regarding the outcome or quality of referrals. Given the concerns raised by secondary care about the number of incorrect referrals being made, this type of feedback would be important in ensuring learning, as well as a mechanism to enable both improvement in the quality of referrals and a reduction in their numbers.

[14] WHC (2015) 022

We feel it is essential that feedback is provided to referring optometrists following every referral submitted to secondary care, to ensure that they are updated on any diagnosis and treatment. Feedback could also safeguard against the rapid access clinic slots being taken up by patients unnecessarily, by reinforcing the importance of the correct use of the pathway.

As previously mentioned, electronic referrals from optometry into secondary care would be a positive step to improve communication between primary and secondary care. Optometrists in Wales have been offered their own secure NHS email addresses which could facilitate this.

Additional issues highlighted as part of the CHC's review related to the information provided to the patients prior to their treatment. Patients felt that they had not been provided with sufficient information within secondary care prior to receiving treatment. It is vitally important that every effort is made by staff to explain the treatment procedure/plan with every patient prior to the treatment they receive, to ensure that there is informed consent.

Treatment and Monitoring

Treatment Timescales – Initial treatment

When confirmation of a 'wet' AMD diagnosis is reached, arrangements should be made for the patient to receive treatment as soon as possible. Royal College of Ophthalmologists guidance states that the current Referral to Treatment (RTT) for treatment following the initial referral is two weeks. The majority of health boards are running two-stop clinics. Patients attend the clinic for an initial assessment and investigations. If further investigation and/or treatment is required a second appointment is arranged. Some areas have adopted a one-stop clinic approach where assessments, investigations and the first treatment (if required) are completed on the same day.

Performance against the two-week target (RTT) was consistently reported to be a challenge by health boards. We saw that there is difficulty in triaging patients and booking them in for their treatment appointment within the two week timescale. This is why some areas have adopted the 'one stop clinic' approach.

We were informed that waiting times for initial treatment did reduce dramatically following the introduction of the Rapid Access Clinics; however, the success of these clinics relies upon the quality of the referrals they receive. False positive referrals reduce the efficiency of the clinics. Performance against the target for initial treatment varies between areas. What is clear is that performance against this target is very inconsistent and fluctuates considerably throughout the year.

Treatment Timescales – follow-up treatment

At the time of diagnosis, the retina consultant will come to a decision regarding the best drug and treatment regime. The initial loading phase of treatment is similar for Ranibizumab (Lucentis) and Afibercept (Eylea)[15] involving three treatments at four week intervals. Thereafter follow up intervals vary. Historically, the patient reviews and subsequent treatment for 'wet' AMD patients has been provided by consultants or staff grade doctors.

We learnt that there are capacity issues in relation to on-going treatment. Most health boards have a backlog of patients resulting in extended follow-up intervals.
A combination of two main strategies have been employed to maximise outcomes whilst minimising demands on the service.

Afilbercept (Eylea) was approved by the National Institute of Health and Care Excellence (NICE) in July 2013. The treatment regime involves three loading doses at four-week intervals followed by eight-week follow-up with treatment at every visit during the first year. In the second-year monitoring continues at eight-week intervals but treatment is only administered if there is evidence of active disease.

The second strategy relates to the Ranibizumab (Lucentis) 'Treat-and-Extend' protocol. The schedule of Product Characteristics (SPC) for Ranibizumab was amended in September 2014, removing a requirement for four weekly follow-up visits. With this protocol the patient receives three loading doses at four week intervals and is then reassessed four weeks after the third treatment. If the condition appears inactive, treatment is administered and the interval to the next appointment is extended by two-weeks usually subject to a maximum of 12-weeks. If the condition appears active, treatment is administered and the interval to the next follow-up is reduced by two-weeks subject to a minimum interval of four-weeks. The treatment cycle continues until there has been no sign of active disease during three visits at 12-week intervals. The aim of this model is to tailor treatment to clinically determined disease activity.

It is vitally important that follow-up intervals specified by consultants are both recorded and followed for optimal results. Health boards should have a system for recording variance between medically recommended follow-up intervals and actual follow-up intervals. This data should be regularly monitored and used to ensure capacity keeps pace with demand.

The problem with providing timely ophthalmology follow-up appointments is not limited to 'wet' AMD treatment. During the course of this review we saw that an alternative Clinical Prioritisation model had been adopted in two health board areas to manage the potential risks associated with ophthalmology follow-up backlogs. The model involves stratifying all patients (new and follow-up) according to clinical need as opposed to generic referral to treatment time targets (which priorities new over follow-up patients). Patients at risk of permanent sight loss (for example retinal detachment, 'wet' AMD, diabetic retinopathy and glaucoma) have the highest clinical priority (P1) and would

[15] is a prescription medication administered by injection into the eye for treatment of patients with Wet AMD, Macular Edema, Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR)

always be seen first. Patients at risk of reversible sight loss (for example cataract) have medium priority (P2) and would be seen if there are no P1 cases waiting. Patients with no risk of permanent sight loss (for example benign eyelid lesions, watery or irritable eyes) have the lowest priority (P3) and theoretically would not be seen until there were no patients with higher priority waiting.

We learnt that there are differing views amongst consultants and health board managers about the practicality, efficiency and sustainability of the Clinical Prioritisation models. Whilst P1 patients are seen promptly, P2 and P3 patients wait lengthy periods with a predictable impact on RTT targets. Some cataract patients have been waited up to 52 weeks for treatment.

Our review has highlighted the need for change to create sustainable eye care services to meet growing demand. In line with the principles of Prudent Healthcare [16], care should be provided for those with the greatest health needs firsts, making the most effective use of all skills and resources available. This will involve changing some established working practices. It is the responsibility of health boards to determine which approaches are utilised to provide follow-up treatment to patients.

Treatment Timescales – targets

We heard concerns from health board staff in relation to the RTT target itself. We were told that while the initial two-week target was helpful and beneficial to patient care, there has previously been no set monitoring or ongoing targets in relation to follow up patient care. However, as part of our review we were informed by the Welsh Government that health boards now have to report on follow up patient care.

We feel that it is important that there is more focus from the Welsh Government and health boards on patient outcomes. The Royal College of Ophthalmologists (RCO) recently published their "Three Step Plan" which sets out to ensure that follow up patients are prioritised in the same way as newly referred patients, to ensure that health board systems monitor and report on any follow-up appointment delays. The RCO recognise that follow up patients are "8-9 times more likely to have a sight threatening condition that needs long term monitoring".

Concerns were raised by staff within Cardiff and Vale University Health Board and Abertawe Bro Morgannwg University Health Board relating to the priorities of the health board management in their areas. The view was expressed that these health boards have prioritised meeting referral to treatment time targets above clinical need for eye care patients. We were told of occasions within CVUHB, when lower risk patients were actively prioritised for appointment slots above those at higher risk of harm. These decisions had been instigated by management overruling clinical views to prevent lower risk patients from breaching an arbitrary RTT target. If this represents a systemic policy it would be cause for serious concern. Health boards must ensure, insofar as it is possible, that patients are treated according to clinical need.

[16] http://www.prudenthealthcare.org.uk/principles/

We also heard concerns around some of the approaches being used by the Welsh Government and health boards to reduce waiting times. These include offering financial incentives to health boards meeting RTT targets, running weekend clinics and outsourcing patients. It may be more effective to concentrate efforts and resources on developing the way services are delivered to maximise capacity. The goal must be to create robust and sustainable services capable of scaling up to meet future demographic challenges, as opposed to spending resources on short-term strategies.

Incident Reporting

Welsh Government has a policy in place which states that where harm occurs to a patient as a result of patients waiting longer than the recommended treatment time to be seen, that the relevant health board must submit a Serious Untoward Incidents (SUI) to the Deputy Chief Medical Officers' Department for consideration. This information is then reviewed and presented to the WG Quality and Safety group monthly meeting.

We found there to be a lack of awareness in the majority of areas in relation to this requirement. Only those we spoke to at Cwm Taf UHB were able to describe in detail the policy/process for reporting SUI's to WG. In other areas there was a lack of awareness of the requirement to report incidents and how to do so.

The majority of those we spoke to explained that whilst incidents are reported via Datix[17], most were unsure about any subsequent action taken by their health board and that they did not receive any feedback in relation to these incidents.

Whilst we have seen correspondence which has previously been circulated to all health board Medical Directors by the Deputy Chief Medical Officer to remind Ophthalmology staff of their responsibility to report any incidents in which harm has occurred. To assist staff, the previous correspondence circulated has also included information defining 'harm' from guidance issued by The Royal College of Ophthalmologists.

Royal College guidelines for the management of age-related macular degeneration 2013 do not define what constitutes a reportable serious incident other than endophthalmitis (a severe infection of the eye). In 2015, the British Ophthalmology Surveillance Unit (BOSU) survey of patients losing vision due to delayed follow-up requested details of patients losing more than 15 logMAR letters (moderate visual loss) or 30 logMAR letters (severe visual loss) from one visit to the next. These definitions have been adopted by Welsh Government in relation to serious untoward incident reporting. Reporting such incidents is an important way to highlight issues within an organisation.

Health boards must ensure that when incidents occur, Serious Untoward Incidents (SUI) reports are submitted, in accordance with Welsh Government policy relating to patient harm. Health Boards must have mechanisms in place to review incidents to spot potential patterns providing early warning of more serious systems failure. When systems failure is detected health boards must provide timely and effective support designed to address underlying issues.

[17] Patient safety software and risk management software systems for healthcare incident reporting and adverse events.

Treatment – Capacity

A key consistent theme emerging from our review has been the deficit between the capacity available and the growing patient demand for ophthalmology services.

We saw that the ability of services to address the backlog of follow-up patients was as great a problem as meeting the initial RTT target. The fragility of services appears to be a major risk, mainly due to an over-reliance on individual medical staff causing delays in patients being seen. A significant proportion of consultant's working time in a traditional treatment clinic is occupied with tasks that can be performed effectively by other members of the multidisciplinary team. Medical staff working alone cannot meet all the demands on the service. The resilience and capacity of services would be strengthened by improved multidisciplinary team working.

In all the health board areas that we reviewed recruitment and retention of staff at all levels (consultants, middle grade staff and admin staff) was reported as a concern. We were provided with a number of examples of the detrimental effect this has had on capability and performance. There needs to be more focus from health boards in developing workforce plans that mitigate the risk of patient care being affected by recruitment and retention issues.

We heard concerns and frustrations from secondary care around the perceived lack of investment in services in recent years. It was felt that investment in services has not reflected the growing demand. For example, concerns were raised by both primary and secondary care staff in relation to the insufficient investment in the service in Wrexham Maelor Hospital. We were told that a consequence of this was that the service was both understaffed and extremely fragile. Furthermore, the optometrists we spoke to from north central and north east Wales told us that they routinely send their 'urgent' referrals to the Abergele Eye Clinic as opposed to Wrexham as they believe their patients will get seen a lot quicker. Whilst those we spoke with in Wrexham told us that their concerns had been escalated to management within the health board; they told us that there has been no action taken to address the issues within the service so far.

Treatment – Initiatives to improve capacity

We feel that health boards need to place more emphasis assessing available skills and capacity in order to identify initiatives that may aid with remodelling the way in which services are being provided.

One such initiative that is being implemented across Wales to increase capacity of services is the introduction of non-medical injectors. Historically, patient injections have been administered by either consultants or staff grade doctors. The introduction of non-medical injectors is intended to reduce the burden on the medical staff and mitigate the risk of bottlenecks from occurring in relation to patient treatment. Before non-medical injectors are able to take on their role unsupervised, they are required to carry out 100 supervised injections alongside a consultant.

We saw that there has been varied progress made in relation to the introduction of non-medical injectors across health boards. For example, Cardiff and Vale and Aneurin Bevan University Health Board's have a number of non-medical injectors (four nurse injectors each) responsible for undertaking a significant proportion of intravitreal treatments. The introduction of these non-medical injectors has had an extremely positive effect on service capacity and there are plans for further expansion of the service.

However, other health boards have not made similar progress with non-medical injectors. Many staff in these areas expressed frustration regarding the lack of progress. We were told that there have been problems backfilling posts and a lack of clarity around arrangements for indemnity. In Betsi Cadwaladr UHB, the issue of indemnity for nurse injectors has delayed progress by around 18 months. Whilst these issues have been resolved, we were informed that funding for these roles has only been secured for 12 months.

We feel that it is important that health boards consider the benefits of introducing non-medical injectors. They have proved to be very effective and beneficial resource to those health boards who have introduced them. Health boards should learn from the experiences of both Cardiff and Vale and Aneurin Bevan Health Boards in attempting to introduce this initiative.

We feel that more consideration needs to be given by the Welsh Government in developing approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales.

The Welsh Government's Planned Care Programme was established to support health boards to improve patient experience by sharing good practice and creating sustainable pathways of care. Given the apparent inconsistencies in the progress that has been made across Wales regarding the introduction of non-medical injectors, we feel that health board Clinical Leads should be encouraged to utilise the Planned Care Board to seek advice from other areas.

Service Support Staff – AMD Coordinators

A number of health boards have appointed designated AMD Coordinators whose main role is to coordinate the service by booking in patients for their follow-up appointments. We heard that AMD Coordinators provide an invaluable contribution and improve the efficiency of services. In some areas the AMD Coordinator is also responsible for collating data relating to patient treatment to establish performance and finance figures. This information has to be supplied to WG Planned Care Board and the health board Finance Team on a monthly basis.

We heard that if inadequate cover is provided when the AMD Coordinator is away from the service, it can quickly become disorganised. This has a direct impact of the effectiveness of the service.

The AMD Coordinators we spoke with explained that the data collection element of their role can be extremely time consuming, primarily due to the inconsistent methods in which information is being recorded. One AMD Coordinator told us that that this task alone took up more than half of the role. We believe that all health boards should give consideration to appointing an AMD Coordinator. Furthermore, health boards should ensure that individuals undertaking the role are adequately supported and that sufficient cover exists during periods of absence. Health boards may even consider appointing more than one AMD Coordinator. The success and efficiency of a service should not be wholly reliant upon one individual role.

Service Support Staff – Eye Care Liaison Officers (ECLO)

We saw the valuable contribution that the Eye Care Liaison Officers (ECLO) provide to patients following referral and confirmation of diagnosis. The ECLO's are responsible for providing emotional support, as well as advice and information to help patients understand their condition and treatment plan. They are also able to identify and link with any other support required for the patient, for example, social services. ECLO's are able to spend a greater amount of time with the individual patient answering any queries/concerns they may have, which frees up consultant time.

Funding for the ECLO role varied in the three areas we visited as part of phase two of the review. In Hywel Dda UHB funding for the ECLO role is provided by Sight Cymru[18]. In Cardiff and Vale UHB the role is funded by RNIB Cymru and in Betsi Cadwaladr UHB the role is funded wholly by the health board

ECLO's cover all eye care services, and whilst there is currently no formal referral process to an ECLO, informal referrals are received from other staff within the service on an ad-hoc basis. ECLO's may also review patient notes themselves to determine whether support may be required for the individual.

We learned that ECLO's had concerns that patients are being asked to attend eye clinics following referrals, but are unsure as to the reason why they have been referred. As previously stated, this issue was also raised as part of the CHC National Ophthalmology Patient Experience Review.

Furthermore, ECLO support is not being fully utilised by all health boards. This may be because not all secondary care staff are aware of, or recognise the role offered by the ECLO and the benefits this role offers patients. More focus needs to be given in educating staff on the benefits the ECLO service offers. In response to their under use, we heard that some ECLO's have resorted to knocking on the doors of staff including consultants to try to ensure that they are aware of and are fully utilising the support available for patients within the service. Clearly this aspect of the service needs improvement in order to improve the patient experience.

[18] Sight Cymru is an independent Welsh sight loss charity.

We were told of the concerns that ECLO's have in being able to provide the required level of emotional support and advice to patients. For example, we were informed that in Abergele there is 32 hours of ECLO time spread over four days a week, which was not felt to be sufficient in terms of the support required for patients. Concerns were also raised in relation to the lack of cover available for the ECLO role, where staff are away from the service, on leave etc. This means that there are occasions where emotional support and advice is not available for patients.

We also learnt that non-medical/support staff experience frustrations in raising concerns within their organisations. Where concerns have been raised with Directorate Leads they have subsequently received very little in terms of feedback. This has resulted in staff not feeling empowered to make suggestions for improvements. Health boards must ensure that there are mechanisms in place to ensure staff are empowered voice their views/ concerns with senior staff and that feedback is routinely provided to them.

Suitability of Environment

We saw that another aspect which impacts the capacity and capability of services to meet growing demand is the suitability of the environments where the eye clinics are provided. We consistently heard concerns from all health boards in relation to the insufficient space and facilities available to deliver services. These issues were impacting on the capability and capacity of the service of meeting the demands of the service. For example, in the Hywel Dda UHB North Road Clinic there has been a restriction placed on the daily intake of patients due to concerns highlighted by Health and Safety in relation to the layout and lack of space within the clinic. Staff at the clinic told us that did not feel that the building was fit for purpose. Whilst we are aware of the health board's plans to develop the estate, we were also told that these plans have been ongoing for two years.

The rurality of services in some health boards, particularly Hywel Dda and Betsi Cadwaladr UHB's is also an issue for patients. This issue was also highlighted as part of the CHC National review. Some patients have to make three-hour round trips to attend appointments at their relevant eye clinic. Given the fact that the majority of 'wet' AMD patients are elderly, this obviously causes issues for them and other family members.

As a result there have been additional services introduced in several areas including a 'one stop clinic' being provided from a GP practice in Crymych, part of Hywel Dda UHB. The introduction of this service has meant that patients within the area now do not have to travel long distances to attend their appointments. The health board are planning to set up similar arrangements with other practices in other areas in the future.

Every health board provided proposals to the Welsh Government to implement their own WG funded pilot service. However, only four health boards were successful. These were Aneurin Bevan UHB, Cwm Taf UHB, Hywel Dda UHB and Powys THB. We were informed that there are plans to independently evaluate each of the pilot services after a year to determine its effectiveness.

Service Development

In July 2015, health boards were asked by Welsh Government to submit bids for pathfinder funding of pilot services to treat 'wet' AMD in a primary care setting. These pilots were originally funded with a timescale to be up and running by April 2016. Welsh Government was deliberately not prescriptive about the requirements because it was felt important for each health board to establish a service bespoke to the needs of its patients.

Every health board provided proposals to the Welsh Government to implement their own WG funded pilot service. However, only four health boards were successful. These were Aneurin Bevan UHB, Cwm Taf UHB, Hywel Dda UHB and Powys THB. We were informed that there are plans to independently evaluate each of the pilot services after a year to determine its effectiveness.

One of the pilots is a primary care based Ophthalmic Diagnostic and Treatment Centre (ODTC) in Aneurin Bevan University Health Board. This one-stop service is being delivered from an optometry practice in Newport city centre close to the bus station and car parks. At present, it is wholly staffed from secondary care but optometrists in the practice have observed and worked with medical photographers to get practical experience of performing OCT scans. Consultants review the images and when necessary treatment is provided by a non-medical injector within the ODTC itself.

Where services have outgrown existing accommodation, expansion into a community/ primary care setting is a positive step for patients and consistent with the principles of prudent healthcare. Adequately staffed and resourced these facilities will reduce pressure on other parts of the hospital eye service. Concerns were raised about secondary care staff providing exactly the same service from a primary care setting.

The role of the Optometrist

In Wales Optometrists who wish to provide NHS treatment/monitoring for patients have to be EHEW (Eye Health Examination Wales) accredited. This is an enhanced qualification undertaken following an optometrists' initial three year degree. EHEW accreditation is achieved by online distance learning as well as Objective Structured Clinical Examinations(OSCEs). Completion of these requirements results in the optometrist being accredited to provide an enhanced service.

Once accredited there is a requirement that professionals will attend compulsory training every three years. This training focuses around themes pertinent to the current eye care issues and/or resulting from the findings of clinical audits. EHEW undertake audits every year.

The vast majority of eye examinations conducted within optometric practices qualify for an NHS fee. The WECS (Welsh Eye Care Services) funding was previously held centrally by the Welsh Government. However, with effect of April 2016 the WECS funding was devolved back to the control of the health board, which meant they will hold the responsibility for clinical governance of optometrists providing NHS care.

The optometrists we spoke with felt that their role was evolving. They are becoming more involved in joint schemes with secondary care and feel that additional responsibility is being allocated to them through WECS referrals. The additional activity that has been allocated to them through WECS has also brought with it extra responsibility and risk. An optometrist cannot 'cherry pick' the WECS activity they wish to carry out, which means there is a lot more pressure in undertaking the role than there used to be, due to the increase in healthcare patients alongside commercial requirements. We were informed that some optometrists have decided to deregister from providing WECS due to the demand and stress caused by the additional role. For example the emergency appointments referred to them via WECS.

The optometrist group discussion sessions we held highlighted that due to the evolving role, there may become a point where optometrists have to decide whether they want to provide healthcare or pursue a more commercial route.

The majority of optometrists we engaged with felt that there were opportunities to remodel the way in which services are being provided to increase capacity and address waiting time issues. Optometrists felt under-utilised and are keen to become more involved in decision making as well as providing follow-up reviews of stable patients, including AMD and Glaucoma patients. A lot of consultant time is being taken up reviewing these patients and there may be an opportunity for optometrists to take on more of a role. This would allow for consultant/medical staff time to be better utilised in focusing on higher risk patients.

To enable more effective utilisation of optometrists, there are other aspects that require greater clarity if the role of the optometrists is to be utilised fully, these include:

- Indemnity protection for optometrists
- Capacity/resource arrangements, to ensure that primary care providers are able to fully meet the WECS requirements
- Finance arrangements for undertaking the additional roles through WECS. For example, for OCT equipment.
- Qualification/training – it was felt that there needed to be more opportunities for more in depth development training to ensure that community optometrists are able to provide hospital standard care to patients. For example, from consultants within the same area. It is of note that various optometrists practicing in Wales are undertaking diplomas in medical retina, including the management of AMD and using OCT scanners. This will provide a source of non-medical AMD practitioners in the near future in Wales.
- Communication mechanisms need to be improved between primary and secondary care. For example, referrals and the sharing of patient information.
- It is notable that there are few hospitals optometrists in Wales compared to other areas of the UK, where hospital optometrists are common place in eye units.

Utilisation of Optometrists

During our discussions with the Welsh Government we were informed that in September 2015, there were between 4000 and 10000 patients per health board waiting to be seen by Consultants. Improved working relationship between primary and secondary care could be invaluable in dealing with this backlog of patients. We have found that the additional utilisation of optometrists to strengthen available capacity has varied across health boards thus far and is an area that requires attention by all health boards.

Progress with the use of optometrists has been predominantly over-reliant on the views and engagement of the consultants within the relevant health board area. For example, we learnt that a consultant in Hywel Dda UHB has agreed a plan with the health board to revamp the way in which stable AMD patients are being reviewed. This plan aims to take advantage of the huge resource potential provided by community optometrists to undertake stable patient reviews.

The implementation stage of this initiative has involved the consultant spending time working alongside the selected optometrists within their practices to ensure that they each receive the required level of support and training to ensure that they become adequately skilled and confident enough to carry out these reviews independently. Phase one of this initiative has involved 60 patients being outsourced to five optometric practices involving seven optometrists within four different towns within Hywel Dda UHB. There are plans for the health board to extend these plans further.

It is hoped that this initiative will mean that the optometrists involved will undertake around 25% of stable patient reviews for the consultant. We were informed that for every 18 decisions that are made by optometrists as opposed to the consultant ophthalmologist, it would equate to one free clinic session for the consultant.

In addition to this initiative, the same consultant has been working with one optometrist to trial another new approach to providing review clinics for all intravitreal service patients (AMD, retinal vein occlusions and diabetic macular oedema).

The optometrist has spent time working alongside the consultant within secondary care to develop the required knowledge/skills to review patients. This arrangement has progressed to the point where the optometrist now carries out review clinics on behalf of the consultant, which again has meant the consultant's time has been freed up to focus on other activity, which has included weekly theatre sessions to undertake patient treatment.

There has been a further development with this initiative which means an additional optometrist has now become involved and there are now plans for these two optometrists to undertake the consultant's review clinics for all of his patients every Monday and Wednesday.

The approaches taken in Hywel Dda appear to have been successful in freeing up consultant time and opening up service capacity. However there has been less progress in the majority of other health board areas relating to the utilisation of primary care optometrists.

In attempting to understand the reasons for this we learnt that consultants held mixed views on the additional use of optometrists. Some felt that optometrists offered a huge resource potential, whereas others had reservations as they felt that optometrists do not have the required level of knowledge and skills to take on the additional responsibility. In one area this has meant that a consultant was previously refusing to accept any referrals from optometrists despite it being the nationally agreed pathway.

The introduction of a WG policy (with effect of 1st March 2016), specified that patients with low risk of ocular hypertension[19] (not requiring therapy), with glaucoma suspect[20] status and following routine uncomplicated cataract surgery were to be discharged to primary care for follow-up reviews. We learnt that there were consultants who failed to follow this policy, due to them having concerns about capability of optometrists to carry out the role and their concerns around patients 'falling through the gap' within primary care, and issues surrounding communication of patients records.

The Wales Low Vision Services is another approach which attempts to utilise optometrists. These services are led by accredited low vision optometrists within the community. Once a patient is referred for an assessment the relevant assessments and paper work are completed by the optometrist. If the patient meets the required criteria, the patient then needs to be seen by a consultant for review, and to register the patient as sight impaired. Once the patient is registered they are able to access a care package which offers more support to deal with their impairment.

Concerns were raised about the efficiency of this approach due to the delays relating to the time it takes for the consultant to register the patient as sight impaired. We learnt that there have been occasions where patients have had to wait up to nine months for an appointment with a consultant. This has a clear impact on patients as they unable to access the support/care package available to them until them have been certified.

It may be worth exploring whether optometrists could be used to certify patients, which would mean that patients are able to access their required support sooner. This would also have the benefit of freeing up consultant time to focus on higher risk patients.

An additional concern raised by optometrists in relation to low vision assessments was that patients are not consistently being referred for an initial low vision assessment by secondary care staff. This means that some patients who may have registrable sight impairments will not be able to access the available support.

Primary and Secondary Care Relationship

HIW believes that poor relationships between primary and secondary care in the majority of health boards has hindered possible progress in development of more integrated services. This appears to be predicated upon the negative views of a small cohort of consultants about the ability of optometrists which has resulted in a 'frosty' relationship between primary and secondary care. Whilst we also heard that in general relationships had improved over the past few years, this issue continued to prevent effective delivery of integrated services.

[19] Ocular hypertension is when the pressure inside the eye (intraocular pressure or IOP) is higher than normal.

[20] The term glaucoma suspect describes a person who does not currently have glaucoma, but one who might be at risk of developing glaucoma.

To improve the working relationships between primary and secondary care, as well as to encourage more focus on integrated working initiatives, the Welsh Government has previously introduced two requirements for all health boards. The first was for health boards to establish their own local Eye Care Group. This group was to include clinical and managerial representatives from primary and secondary care, the Community Health Council and local third sector organisations. They are aimed to provide a forum to discuss issues of concern, develop lines of communication, build trust and foster joint working initiatives. The second requirement was for all health boards to recruit an Optometric Advisor, whose role it would be to work with colleagues within secondary care to improve working relationships and facilitate the introduction of initiatives to deliver more joined up services. At the time of our review, every health board with the exception of Betsi Cadwaladr, had successful recruited a permanent Optometric Advisor into post.

The health boards which had recruited Optometric Advisors felt that there had been a very positive impact in the relationship between primary and secondary care staff following the introduction of the role. However, further improvements were required to enhance the working relationships and initiatives being introduced. For example more opportunities for optometrists and ophthalmologists to spend time training/ working alongside one another in each of their own respected areas to build up clinical experience, knowledge and awareness of roles as well as building on working relationships.

Overall, we were informed by primary and secondary care staff that relationships have improved. However, further progress is required in many areas, for example better utilisation of Eye Care Groups in some areas.

Discharging Patients

Discharging Patients – criteria

A key issue that we found during our review related to effectiveness of patient discharge from secondary care. We found that in the majority of areas there are very few 'wet' AMD patients discharged from secondary care once they have been referred. We were told that health boards had policy/criteria available to determine whether a patient was stable enough for discharge; that a patient can be discharged if they have not received/ needed treatment in the past 12 months.

Royal College Guidelines (2013) state that permanent discontinuation of treatment should be considered if:

- best corrected visual acuity in the treated eye drops below 15 letters (1.40) on three consecutive visits despite optimal treatment
- there is a reduction of best corrected visual acuity by 30 letters or more compared either to baseline or best recorded level since baseline

The Guidelines go on to recommend that discharge should be considered if:

- a decision to discontinue a licenced anti-VEGF agent permanently has been made
- if there is no evidence of other ocular pathology requiring investigation or treatment
- there is a low risk of worsening or reactivation of 'wet' AMD (e.g. very poor central vision and a large non-progressive, macular scar).

In Aneurin Bevan University Health Board any patient whose first treatment was more than two years ago, and last treatment was more than one year ago, is discharged to the retina clinic for full ophthalmic assessment prior to a decision regarding final discharge. Patients are given a leaflet explaining symptoms to look out for, a contact telephone number and encouraged to contact the clinic directly in case of any problems. Since 2009, 55 (16%) of patients discharged with inactive lesions according to these criteria have restarted treatment for the same eye.

Following our discussions with staff we have concerns that there is potentially a lack of consistency in applying discharge criteria. This may result in patients being followed up unnecessarily or treated with little chance of benefit. This clearly impacts on demand for secondary care services. Health boards must ensure that there is a discharge policy in place, in line with Royal College Guidelines (2013), and that relevant staff are reminded of the importance of following the policy.

There is potential for some stable patients to be discharged for routine monitoring in primary care, releasing capacity in secondary care. This would ensure that consultant time is focussed on managing higher risk patients.

As previously mentioned, from 1st March 2016 a new Welsh Government (WG) policy was introduced for discharging patients following routine uncomplicated cataract surgery, those with low risk ocular hypertension not requiring therapy and those with glaucoma suspect status into primary care for follow up reviews. The aim being to reduce the burden on secondary care by utilising the available capacity offered by optometrists. In order to provide these new services optometrists had to attend one of the events across Wales incorporating training on cataract and glaucoma to ensure that their knowledge was current. However, following the introduction of the policy was met with reluctance from consultants in some health boards. Again this relates to concerns from some consultants regarding the capability of optometrists to carry out the required roles.

Discharging Patients – quality of information

We heard concerns in relation to the lack of information available to optometrists when a patient attends their practice following discharge from secondary care. The current process is that patients are discharged with documentation to take with them when they visit their optometrist. It appears however that this does not routinely happen, and optometrists have to rely on the patient's memory/understanding of the treatment they have received and what they were told by their consultant regarding monitoring to determine the action required. This is clearly not acceptable and has the potential for key information not being provided to the optometrist.

There needs to be more focus on improving the information available to optometrists for patients that have been discharged. Optometrists told us that it would be extremely useful to have access to information on diagnosis and treatment provided to help them determine the level of monitoring required. It would also reduce the chance of unnecessary re-referral back to secondary care. The information provided to the optometrists should also include confirmation as to whether the patient has been registered as sight impaired.

In terms of addressing this problem, one suggestion put forward to us was for consultants to discharge to a specific optometrist, which could be the patients' preference. This approach would allow for the consultant to contact the selected optometrist via letter or telephone to update them on the diagnosis and treatment as well as the level of monitoring required. This approach could also aid in building working relationships between primary and secondary care. This solution, or any other proposed solution would have to be considered in line with the WECS requirements/ arrangements however. The introduction of an electronic patient record accessible in primary as well as secondary care could also assist with issues such as access to relevant information regarding patient status and history.

Information Management Systems

Information Management Systems – Planning

A consistent issue that emerged during our review related to information management systems. Information appears to be captured in different ways within the same health board areas. This impacts the ability to accurately collect data in relating to patients being seen/treated by services. For example, we were told that in some areas information is being recorded on paper which means that the only way to undertake any audit of patients treated is for a member of staff to physically trawl through the paper documentation.

It was felt by staff that consistency in data collection was an area which required more attention. In todays' digital age the collation of data on paper only leads to a multitude of issues, not least information security.

We heard that the IT software available within health boards was a concern. It was felt that the software available was not adequate to capture and extract data required for effective operational management of services. For example, the lack of ability to effectively report and analyse capacity and demand information. As a result there is very limited understanding within health boards of capacity and demand data currently.

Health boards are required to submit data for each of the main care pathways including AMD to the WG Planned Care Board on a monthly basis. The information includes capacity, number of referrals, new treatment stats, follow-up appointments and treatments. Given the IT issues highlighted above, this has proven to be an extremely difficult and labour intensive process and we were informed most health boards rely on manual data extraction to obtain at least some of the information.

All health boards need a far more detailed understanding of capacity and demand data to manage ophthalmology services effectively. A system to automate collection of this data would facilitate informed workforce and strategic planning around changes to existing services and implementation of new ones. It is only by quantifying demand-capacity gaps that resources can be fairly allocated according to patient need.

Information Management Systems – Sharing information

The IT systems currently available within health boards are not equipped to effectively share clinical information between multiple sites. This can cause problems for the services. An example provided was in relation to OCT scans, where there are issues when trying to view OCT images as they cannot always be shared across different health board areas due to networking issues. This causes difficulty for staff, results in duplication and impacts upon continuity of care, as well as the efficiency of the service. We heard concerns that the introduction of additional community based sites may exacerbate this issue

We believe that greater emphasis needs to be placed on improving access to information so as to improve efficiency of secondary care services across multiple sites, as well to ensure that the community based initiatives being introduced are not hindered by lack of access to patient information. Improvements in the capability of information sharing would also aid the utilisation of additional use of primary care optometrists.

During our discussions with staff we were informed that meetings have been held between relevant staff and NWIS to attempt to enhance the information sharing mechanisms available to staff.

As highlighted in a previous section, there needs to be more focus in relation to the introduction of electronic patient records and electronic patient referrals. We were told that there are plans by WG to progress with electronic referrals and optometrists felt that the recently provided NHS email addresses could be utilised in progressing with this.

Public Awareness

We believe that increased public awareness of 'Wet' AMD is required. This needs to include the symptoms to look out, associated/linked eye conditions, and the importance of seeking advice, from the relevant healthcare professional, quickly. There are concerns that some patients are waiting too long to seek help which given the risks of irreversible eye damage with the more serious conditions, could have detrimental impact on their eyesight.

The public perception of optometrists needs to be changed. The majority of people associate optometrists as more of a commercial profession than healthcare. An increase in the awareness of all services available to deal with eye care related issues could also mean a reduction in the patients attending secondary care unnecessarily.

More needs to be done to manage the expectations of patients once they are referred onto the 'Wet' AMD pathway. Issues were highlighted as part of the CHC National Review in relation to continuity of care, i.e. patients seeing different healthcare professionals as part of their care. Most patients believe that the consultant is the best person to speak to, however, this may not always be the case and given the changes to the service pathways that are being introduced. Patients need to be made more aware of the other professionals who are able to monitor/treat them in relation to their eye healthcare included nurses and optometrists.

5. Conclusion

The aim of this review was to identify any issues in the delivery of the 'wet' AMD pathway and to highlight examples of good practice. It is clear to the review team that many of the lessons learned can be applied more broadly to other aspects of the ophthalmology service.

It is almost ten years since the first intravitreal injection for 'wet' AMD in NHS Wales. Newly appointed consultant ophthalmologists have no direct experience of a time without an effective treatment for what is the most common blinding disease in Wales. Despite the challenges facing services and documented in this report, many patients continue to benefit from treatment, retaining much better vision, quality of life and independence than was thought possible before. We acknowledge the dedication and hard work of multidisciplinary teams across Wales who make this possible, sometimes working in difficult conditions.

The two-week referral to first treatment target is a significant challenge. It is difficult for optometrists in primary care to detect early signs of 'wet' AMD and there is a tendency to err on the side of caution. A referral refinement system to include logMAR acuity and OCT scan, reviewed by one of the retina team, can reduce the number of urgent appointments and maximise efficiency of Rapid Access Clinics in secondary care.

Intravitreal therapy services are still expanding rapidly, outgrowing facilities and stressing the systems around them. Demographic projections[21] indicate that this trend will continue for the foreseeable future. All intravitreal services must have a realistic plan for future expansion. There is a long lead-in period for developing new treatment facilities, even when funding has been assured from the outset. This should be factored into plans.

The number of ophthalmologists in training remains static[22] and as middle grade doctors retire they are very difficult to replace. Given recruitment difficulties in parts of Wales there is unlikely to be significant expansion in the ophthalmology workforce. Health boards need to consider how their services can be developed to fully utilise all available resources, including the introduction of non-medical injectors. There is a long lead-in period for the first group to go through training and activity will necessarily be reduced during this phase. The long-term benefits to the non-medical injector service are significant. Some thought should be given to the most effective way of deploying non-medical injectors. This depends on the clinic set up.

There has been an increase in the number of optometrists in training[23] and this sector of the eye care workforce will expand significantly in future. Many eye units in other areas of the UK make extensive use of hospital optometrists for service delivery. They typically work in the following clinics: macular degeneration treatment, diabetic retinopathy management, glaucoma monitoring, cataract assessment and emergency eye clinics.

[21] Clinical Council for Eye Health Commissioning: Community Ophthalmology Framework July 15.
[22] Health Education England: Proposed Education and Training Commissions for 2015/16.
[23] General Optical Council (GOC): Annual Performance Report 2016.

Traditionally, eye units in Wales have employed relatively few optometrists. This is a potential area for future workforce expansion.

We identified that cases of significant vision loss during treatment are probably under-reported in most units. Consideration should be given to streamlining the incident reporting process to encourage more reports.

Whilst our review highlights that progress has been made to improve services, these improvements have been inconsistent across Wales. Additional workforce planning is required to ensure that services are developed to maximise the available capacity to meet the growing demand for eye care services.

Following on from this review, HIW will be undertaking follow-up activity on recommendations made. This is to ensure that health boards are being vigilant in addressing these matters and taking all necessary action to improve the issues highlighted in our review.

Appendix A – Recommendations

As a result of the findings from our review, we have included the following overarching recommendations for health boards and policy makers to consider.

	Report finding	Recommendation info
1	Issues relating to patient referral process **(Patient Referrals – Referral Process)**	All parties (Welsh Government, NWIS, Ophthalmology Planned Care Board and Health Boards) must work together towards the introduction of electronic patient record/ referral system from optometrists directly to secondary care.
2	The CHC's National Ophthalmology Review highlighted that some patients felt they had not been provided with sufficient information regarding the reason for their referral. **(Patient Referrals – Referral Process)**	Health Boards via Local Eye Care Groups should work with optometrists to ensure that patients are provided with adequate and accessible information regarding the reason for their referral to secondary care and ensuring that all patients feel listened to and involved in decisions made around their care.
3	Quality of referrals being sent to rapid access pathway. **(Patient Referrals – Quality of Referrals)**	a) Health Boards should consider methods to refine referrals to ensure patients enter the most appropriate care pathway in a timely and efficient manner, avoiding unnecessary visits. b) Health Boards should consider providing educational events/material to raise awareness among optometrists and other relevant staff of local referral pathways. c) Health Boards should ensure feedback is provided to optometrists when required relating to quality of referrals sent to ensure learning.
4	Lack of feedback provided to optometrists following referral and discharge of patients. **(Patient Referrals – Communication Following referral)** **(Discharge patient – Quality of information)**	a) Health Boards should ensure feedback of diagnosis and a treatment plan is provided to referring optometrists following every referral made to the service, including whether a referral to a low vision service has been made. b) Optometrists must use the appropriate referral form and ensure that their name and practice address are clearly legible. c) Health boards/Welsh Government must ensure that systems are introduced to improve the amount of information available to optometrists in relation to patients who have been discharged from secondary care.

	Report finding	Recommendation info
5	CHC reports concerns around lack of information provided within secondary care prior to treatment. **(Patient Referrals – Communication Following referral)**	Health Boards must ensure that patients are provided with adequate information about their condition and proposed care plan prior to any investigation or treatment. This should conform to the principles outlined in GMC guidance on informed consent.
6	Concerns around set monitoring for follow-up patients. **(Treatment Timescale – Targets)**	a) The Welsh Government should ensure that Patient Administration Systems are capable of providing data on clinician recommended follow-up interval and actual follow-up interval by care pathway. b) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available. c) Clinical teams must clearly document the follow-up regime selected for each case. This should be applied consistently according to agreed protocols. The patient should be kept informed of any changes to the plan.
7	Lack of incident reporting relating to WG patient harm policy. **(Incident reporting)**	a) Health Boards must ensure that there are mechanisms in place to review incident reports to identify potential patterns providing early warnings to more serious system failures. b) Health Boards must ensure on the occasions where any incidents occur, inline with the WG policy related to patient harm, that these are reported as Serious Untoward Incidents (SUI's).

	Report finding	Recommendation info
8	Lack of capacity/Fragility of services of services due to over-reliance on consultants. Issues relating to lack of capacity, recruitment and lack of investment in services. **(Treatment – Capacity)**	a) Health Boards must proactively develop workforce plans which set out to address any shortfalls in the current service capacity and available facilities to mitigate the risks to patient care. These plans should seek to maximise capacity by making most effective use of the skills of medical and non-medical staff available, as well as available space/facilities. b) Health boards must consider ways to work more closely with colleagues from primary care. For example, providing equipment (and training) to optometry practices to allow them to undertake referral refinement and/or assessments on stable patients. This needs to be done in a planned and strategic way under control of the health board.
9	Health boards should learn from the experiences following progress made in other areas. **(Treatment – Initiatives to improve Capacity)**	a) Health Boards must ensure that they fully engage with the Ophthalmology Planned Care Board to aid shared learning from/ with staff in other areas. b) Welsh Government should consider whether there is a need to develop further approaches to encourage shared learning between health boards as well as more integrated methods to address common themes/issues being experienced across Wales. For example, the introduction of non-medical injectors.
10	Importance of the AMD Coordinator role. **(Service Support Staff – AMD Coordinators)**	Due to the demands of the role and the importance of providing continuity of cover, consideration should be given by Health Boards as to whether one AMD Coordinator is sufficient for the eye care service.
11	ECLO – lack of utilisation of the role from other staff. **(Service Support Staff – Eye Care Liaison Officer)**	Health Boards must ensure that all staff are aware of the availability of the local ECLO service. Ensuring patients have access to relevant advice and support.
12	ECLO – Limited capacity/cover. **(Service Support Staff – Eye Care Liaison Officer)**	Health Boards should ensure that there is ECLO for their eye care clinics at all times and consideration should be given as to whether one ECLO is sufficient for the eye care service.

	Report finding	Recommendation info
13	Concerns raised by staff in relation to a lack of processes in place to submit comments/ suggestions to health board management. **(Service Support Staff – Eye Care Liaison Officer**	Health Boards must ensure that there are methods in place to allow all staff to raise any concerns/suggestions about improvements to service provision they may have. This process should to ensure that feedback is routinely provided to individuals.
14	More clarity required in relation to evolving role of optometrist. **(The role of optometrist)**	To enable more effective utilisation of optometrists, Welsh Government must provide clarity to health boards relating to Indemnity, resource & finance arrangements, training/qualifications and communication mechanisms.
15	Additional utilisation of optometrists is required to increase capacity (HDHB example) and reduce the burden on secondary care. **(Utilisation of optomoterists)**	Health boards should consider additional utilisation of optometrists to increase available capacity and reduce burden on secondary care. Health Boards will need to ensure that issues are clarified around Indemnity, resource & finance arrangements, training and communication, for optometrists.
16	Patients not always being referred for their initial low vision assessment by secondary care staff. **(Utilisation of optometrists)**	Health Boards must ensure that staff are reminded of the importance of referring all eligible patients to an accredited optometrist for a low vision assessment.
17	Issues in relation to poor relationships between primary and secondary care staff impacting on progress to service developments. **(Primary and Secondary Care Relationship)**	Health boards must ensure that relevant staff engage with the local Eye Care Group. The group should meet regularly and be chaired by a member of the executive team. A key objective is to improve the working relationships between primary and secondary care staff to foster joint working initiatives.
18	Betsi Cadwaladr UHB did not have optometric advisor in post at time of our review. **(Primary and Secondary Care Relationship)**	Betsi Cadwaladr UHB must ensure that a permanent optometric advisor is recruited into post in line with the WG requirement.
19	Concerns raised about different criteria being used by different consultants, which subsequently means some patients are being followed up unnecessarily or treated with little chance of benefit. **(Discharging Patients – Criteria)**	Health Boards must ensure their AMD service has a policy setting out criteria for discharging 'wet' AMD patients in line with Royal College Guidance. The aim being to ensure that patients do not remain within the service longer than required. Maximising capacity for patients most likely to benefit. Adherence to the policy could form part of the annual service audit.

	Report finding	Recommendation info
20	Inadequate IT systems to capture useful date. Limited awareness of capacity and demand data. **(Information Management Systems – planning)**	Improvements must be made to information management systems within health boards to enable accurate capturing of capacity and demand (performance) data to allow for more informed workforce planning and to ensure resource provisions are based on patient need.
21	Issues in relation to information sharing. **(Information Management Systems – sharing information)**	Improvements must be made on improving the access to/sharing of patient information within health board areas to improve efficiency of services.
22	Lack of public awareness in relation to general eye care. **(Public Awareness)**	Welsh Government , Public Health Wales and Health Boards need to consider how the general public can be made more aware the importance of regular eye checks, general eye care issues, as well as the symptoms to look out for which are associated with the more serious eye conditions and the importance of seeking healthcare advice quickly. More information needs to be provided on the different services/professionals available to see/treat patients in relation to their eye care conditions.

NHS eye care services in Wales:

What improvements have health boards made?

January 2020

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

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Introduction

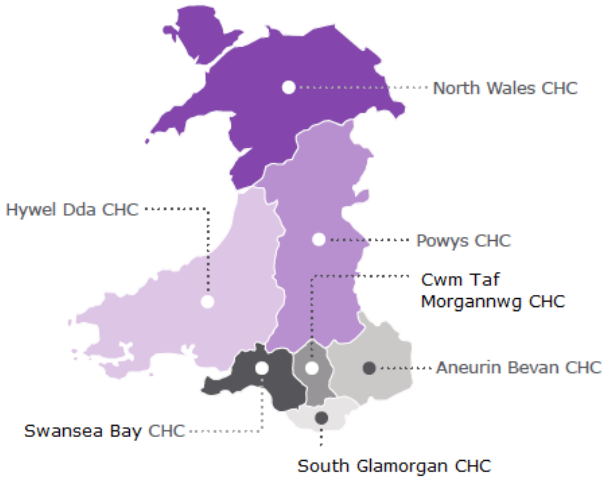
This report has been produced by the Board of Community Health Councils on behalf of the 7 Community Health Councils (CHCs) in Wales.

CHCs are the independent watchdog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

CHCs work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CHCs maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, complaints advocacy service, visiting activities and through public and patient surveys.

Each of the 7 CHCs in Wales represents the "patient voice" within their respective geographical areas.



This report sets out the progress reported by NHS bodies to improve eye care services across Wales since we first reported what people told us about their experiences in 2016.

What we did

According to the NHS in Wales, nearly 111,000 people in Wales are living with sight loss. This is estimated to increase by a third by 2030 and double by 2050.

In 2016, 6 Community Health Councils (CHCs) in Wales (excluding Cwm Taf Community Health Council) asked people attending NHS eye clinics what they thought about the service they were receiving. We did this because we had heard that people were waiting too long to get the treatment they needed for their eye condition.

We reported what people told us in a national report "National Ophthalmology (eye-care) Patient Experience Review" published in July 2016[1].

[1] http://www.wales.nhs.uk/sitesplus/899/opendoc/297139

The key national themes we identified in 2016 were:

- Most people were happy with the eye care treatment they received locally in the community (primary care) and in hospital
- Most people were very happy with the approach, attitude and treatment by healthcare professionals – although a few thought that the attitude of some consultants could be better
- Some people thought they had to wait too long to be seen when attending an eye care clinic
- Some people thought they had to travel too far to attend an eye clinic, and when they got there parking was often difficult
- Some people felt that appointment arrangements could be improved and were concerned about cancelled appointments
- Some people thought communication and information could be clearer. This included when healthcare professionals were explaining their eye condition and treatment options, and what to do if they had worries or concerns about their condition or treatment
- Some people had concerns about 'continuity of care' and seeing lots of different healthcare professionals
- Some people who needed on-going treatment were worried about how long they had to wait for follow up appointments.

CHCs asked each of the 6 health boards to make improvements in response to the things people said about the services in their area.

In 2017, Cwm Taf CHC (now Cwm Taf Morgannwg CHC) also asked people in their area what they thought about eye care services. Their feedback was similar to the things people raised in other parts of Wales.

Since then, CHCs have heard some continued concerns about the problems being faced by people on waiting lists for eye care treatment.

These concerns were not only about first appointments, but follow up appointments. This is because regular reviews or treatment might be needed to make sure a person's sight improves or to reduce the risk of avoidable blindness.

This led to the introduction in April 2019 by the Welsh Government of a new measure designed to make sure that new and existing patients are seen or treated within an agreed timeframe based on their clinical condition.

The Welsh Government has said that the main purpose of the measure is "to ensure that:

- All individuals who are referred to hospital for ophthalmology will have a maximum waiting time which is based on a clinical assessment of their condition and well-being; and
- All ophthalmology patients who require regular ongoing review or treatment will be seen within clinically-indicated intervals, which are also based on their condition and well-being, and should be reviewed at each appointment".

In June 2019 CHCs asked each health board in Wales to tell us what it had done to improve eye care services since our earlier report.

What we found

Improvement actions - common themes across Wales

All 7 health boards told us what they had done and what they were still planning to do to improve their eye care services.

Unsurprisingly, the introduction of the new national eye care measure had led to a number of consistent actions across Wales. This included reviews of the eye-care 'pathways' and new ways of delivering services closer to people's homes.

The development of new approaches

Health boards reported a range of new approaches designed to improve eye care services across Wales. The most common of these included:

Digital communications

A number of health boards reported the introduction of automated booking systems and text reminder services for new and follow-up patients.

Some areas were already able to demonstrate more people are attending their appointments.

National digitisation of service-user records

Health boards told us about the digitisation of medical records. This is designed to share patient information easily across all parts of the NHS so that patients don't have to repeatedly share the same information with different healthcare professionals.

Community-led service units

Some health boards have opened Ophthalmic Diagnostic Treatment Centres (ODTCs) in their areas. They told us this meant that for some people they don't need to attend hospital.

Instead, they can attend their first or regular appointments closer to home. This included people with conditions such as glaucoma, Age-related Macular Degeneration (AMD) and diabetic retinopathy.

These changes have also meant that specialist consultants time can be better used.

Outsourcing services

Some health boards told us they had provided people with an option to have their follow up appointments 'outsourced' with independent eye-care services.

People who choose this option may be seen more quickly than they would if they wanted to wait for their regular service.

Local eye-care groups

Each health board told us they had introduced eye-care groups in some form. These internal groups monitor the performance of the service and aim to listen and learn from patient feedback and outcomes.

What's happening locally

The following section sets out the progress reported by individual health boards.

Aneurin Bevan University Health Board	
What we said needed to get better	**Progress reported by the health board**
The health board should share patient feedback: • highly positive patient satisfaction around their overall clinical experience • highly positive patient satisfaction around inpatient experiences • with primary care providers about the need to ensure that patients fully understand the suspected problem with their eyes and that they feel involved in decisions made around their care The health board should consider patient feedback around: • follow up appointments not taking	**Community-led services** • To improve service user access to appointments for the condition of Glaucoma, the Gwent area now has six Ophthalmic Diagnostic Treatment Centres (ODTCs) open with a community clinic setting. These centres can review new and follow-up patients in a setting closer to the patients' home and reduces the need to attend a hospital environment. • A new community based Wet-AMD service is available in the Newport area and also within two hospital clinics (Nevill Hall Hospital and Ysbyty Ystrad Fawr. The health board has identified that the demand on this particular service is increasing and has resulted in follow-up delays due to capacity constraints. The health board said that this is being off-set to some degree by utilizing the "Treat and extend" protocol. The health board is writing a business case to request resources to increase capacity; this includes a review of the resources required

place on time - cancelled first and follow-up appointments - experiencing unnecessary delays for first and follow-up appointments - telephone access to booking clerks e.g. quicker responses - feeling listened to and involved in decisions made around their care - some eye clinics appear "overbooked" The health board should ensure all patients: ▪ received enough information to consent to treatments. ▪ are advised of what to do if they have any concerns or worries about their condition or treatments.	for Nurse Injectors. It is hoped that this additional resource will improve access for Wet-AMD patients and reduce follow-up delays. - The health board said that continual feedback is gathered and a 98% patient satisfaction rate has been found with regards to ODTCs. **Extended roles** - To improve service user access to clinical reviews and prescriptions, optometrists are being trained to become independent prescribers. This provides a one-stop service to some patients and also releases Consultant capacity and activity. **Digital communications** - The health board has introduced the Dr-Doctor text reminder service to improve communication with service users and offer reminders of scheduled appointments. A review of this service has shown there has been a 9% reduction in missed appointments slots. **New ways of working** - The health board has introduced a Primary Care Macular Referral Refinement Service, which has improved the quality of primary care referrals and has reduced the need of inappropriate referrals being called for a review within the secondary care eye services.

	• To improve service capacity and activity, the health board has been successful in recruiting Consultants with more adverts to follow for general/Cataract surgeon and emergency eye services.
	
	• The Health Board currently operates **an outsourcing initiative** to improve waits for patients who wish to accept the offer of an appointment with Care UK. Patient feedback is sought for this service and appears to find "excellent" service user feedback.
	
	• To improve access to the booking clerks via telephone, the booking service is now co-located within the Directorate to improve access to service users and communication within the team.
	
	Communication with service users
	
	• The health board has a well-established Eye-Care group in place, which includes representatives from the RNIB (Royal National Institute of Blind People)[2] to advise on patient inclusion and communication. Specific improvements to patient communication includes;
	
	  ○ The health board's website for eye care services is nearing completion.
	  ○ Explanation videos will be developed for specific eye conditions to support patient information and understanding.

[2] https://www.rnib.org.uk/

	○ New guidance has been received regarding consent. The new guidance ensures patients are given and receive sufficient information about their treatment or surgery options. ○ Leaflet handouts are given to patients to explain what to do if they have any worries about their care or condition. ○ The recommendation to feedback to Primary Care was delivered through the collaborative groups to ensure that patients fully understand why they are being referred on to the eye-care service and that the patient is involved in making that decision.

What else needs to happen now?

The health board needs to take action to better meet demand within the Wet-AMD service

Betsi Cadwaladr University Health Board	
What we said needed to get better	**Progress reported by the health board**
The health board should share patient feedback: • about satisfaction with the booking of first appointments • around feeling listened to, but note the comments around having the opportunity to talk and also an individual's concern of experiencing pain • about high patient satisfaction around being involved in decisions but note some comments around "plain speaking" and "explaining more" • around high levels of satisfaction for receiving enough information to consent to treatments • about high levels of satisfaction around diagnosis being fully explained to patients, but note the comment/suggestion of	**Community-led services** • New Ophthalmic pathways such as; optometric follow-up post cataract procedure have been designed to minimise the number of hospital site visits required and therefore delivering follow-up care closer to the patients' home. **New ways of working** • The health board has been working with the Welsh Government's Planned Care Programme to reduce hospital initiated cancellations but provided no further impact analysis to demonstrated a reduction in the cancellations for patients. • Delivery of Integrated Pathways, which will maximise effectiveness and reduce delays for patients, has commenced. These pathways optimise the use of clinical time and skills to enable timelier access to services. • As part of the new national Eye-care measures, the health board commenced risk factor bookings in June 2019, and are working to address the current backlog of patients. **Communication with service users**

patient information leaflets • about high levels of patient satisfaction around their clinical experiences however, some individual concerns should be considered • around inpatient experiences. The health board should consider patient feedback around: • follow-up appointments not taking place on time • the cancellation of first and follow-up appointments • experiencing unnecessary delays for first and follow-up appointments. The health board should ensure: • all patients are advised of what to do if they have concerns or worries about their condition or treatment	• To improve the level of communication and information sharing with patients the health board reported: o An increase of communication with patients is being delivered via post-clinic letters for referring to following patients' clinic attendance. o The health board is looking to develop information resources for patients following the redesign of the Cataract pathway. o The health board explained that points of contact are given to patients at appointments and also the contact details for the RNIB helpline. o A refresher session is to take place with Primary Care providers about specific conditions information leaflets for patients i.e. Cataract information leaflet to be given to the patient at the point of referral and again within the Health Board's acknowledgment letter to the patient. Audio/Audio-visual formats of information are being explored. o Videos and media content for clinic waiting areas are being developed (specific to cataract clinics). o EIDO (condition specific) information leaflets are routinely shared within clinics and prompts are given throughout a

☐ Primary care providers offer enough information to patients around the suspected problem with their eyes and ensure that patients feel listened to.	patients' pathway to check understanding. (EIDO are an organisation that provide model patient leaflets).

What else needs to happen now?

The health board needs to share with its CHC what patient experience measures are in place for monitoring and responding to patient feedback.

Cardiff & Vale of Glamorgan University Health Board	
What we said needed to get better	**Progress reported by the health board**
The health board should share patient feedback: • About patient satisfaction with their clinical experiences (but also note comments around cancelled operations and treatment time scales). • About highly positive inpatient experiences • that patients felt involved in decisions made around their care during their first appointments • that healthcare professionals fully explained conditions to patients in a way they could understand. The health board should consider: • patient feedback around follow-up appointments not taking place on time • the views of some patients who felt that first appointments and follow-up appointments were	**Community-led services** • To support timely access to follow-up reviews, the University Health Board has increased capacity in the community setting for follow-up clinics in the specialties of AMD, Glaucoma and diabetic Retinopathy. **New ways of working** • In relation to patient feedback about follow-up appointment delays and the introduction of the new All Wales Eye-care Measures, the University Health Board has introduced a robust data management system to identify patients due to been seen and priorities their appointment in line with their risk rating. **Digital Communication** • A fully automated booking and text reminder service is in place for new patients and text reminders are in place for follow-up patients. A review of this service has shown an improvement in attendances and better utilisation of appointment slots. **Learning from concerns and service user engagement**

subject to unnecessary delays and that this resulted is some dissatisfaction with the appointment booking process and waiting times • the views of some patients who felt that they were not involved in decisions during their follow-up appointments The health board should ensure: • all patients feel listened to • all patients are advised of what to do if they have any concerns or worries about their condition or treatment. • all patients are treated sympathetically.	• The health board actively review concerns and complaints raised by patients about cancellations to prompt quick learning and improvements where necessary and possible • To ensure that patients feel listened to, the health board has introduced the "2 minutes of your time" patient questionnaire. The patient feedback and satisfaction results are reported to and monitored by the Health Board's QSE. • There are plans going forward to roll out the patient satisfaction survey to all out-patient areas (including Ophthalmology) which will then be summarised in to a "You said, We did" format for displaying in public areas. **Communication with service users** • To ensure that patients are advised of a point of contact should they have any worries, the health board has introduced "support letters", which sets out what an individual needs to do if they have any concerns. • To increase patient information resources, the health board's ophthalmology website offers detailed information on clinical advice.
What else needs to happen now?	

The health board needs to share with its CHC the impact of offering additional community-based services and the level of patient satisfaction in this area.

Cwm Taf Morganwwg University Health Board	
What we said needed to get better	**Progress reported by the health board**
• Ensure that all patients are informed of what to do if they have any concerns or worries around their condition or treatment. • Share with Primary Care providers the national patient feedback around offering adequate information/ explanation to patients about the suspected problem with their eyes. • Patients that use buses described difficulties in having to take more than one bus to get to clinic. The difficulty encountered by car users is the availability of car parking spaces. • Reinforce to clinical staff the importance of sharing information with patients about their treatment to include side effects of treatment.	**New ways of working** • To improve the timely review of follow-up patients, the health board has commissioned an **outsourcing initiative.** Follow-up patients are reviewed and letters are sent to them to offer an outsourced review, with further information about who to contact about their follow-up. The health board acknowledges that performance in this area "remains a considerable concern and is a national concern". • The health board holds regular Referral to Treatment Time (RTT) meetings, and reports are submitted to the Clinical Business Meeting. A "follow-up appointment project board" has been introduced to monitor follow-up patients and their pathways. • As of 2017-18 – no patient waited more than 12 months for their first appointment. As at July 2018, no patient was waiting over 36 weeks for their first appointment, this was maintained to the 31st March 2019. • The health board is now fully committed to moving its waiting time performance to the new Health Risk Factors standards and reporting has just commenced with Welsh Government in June 2019.

• Consider how the role of the Eye-Care Liaison Officers (ECLO) could be better advertised so that patients can access this resource as the minority of patients who knew about it described to the CHC as very helpful. • Ensure that information leaflets are shared with patients either in hard copy or electronically. • Consider including information about estimated waiting times whilst in the Clinic waiting room in either the Patient Information leaflets or via other means of communicating with patients. • Share information with patients about the prioritisation of their appointment and current projected timescales before they can be seen. • The health board has made some progress in reducing waiting times for first appointments with 63% of	**Parking access** • Access to parking at the Royal Glamorgan and Prince Charles Hospitals has been increased with additional car park spaces, however, this has not totally resolved the difficulty. Transport concerns will continue to be picked up where identified via the Equality Impact Assessments (EQIA). **Communication with service users** • To ensure that patients receive information about their treatments and any side effects, this recommendation was highlighted to clinicians via their sub-directorate meetings. • Clinical staff were reminded at their sub-directorate meetings to be vigilant in offering service users information in relation to the Eye Care Liaison Officers. The CHC were informed that patient information leaflets had also been updated with this information. • All patient information leaflets were reviewed at the health boards **Eye Healthcare group** to ensure they were up to date. Clinic rooms will be checked regularly to ensure adequate stocks and availability. • The health board has explained that should patients wish to find out about the potential waiting times within clinics, this information can be sought via telephone for up to date

those surveyed confirming that they had not waited for more than 6 months to be seen. • Nevertheless this does leave 37% of patients waiting for more than 6 months for a first appointment. Some patients report having waited longer than 1 year for their first appointment. • A few patients in their additional comments identified an issue in relation to the availability of their patient files which they consider led to delay in their treatment. Clarify whether there are any issues in relation to the availability of patient files and assure itself that appropriate systems are in place to avoid any delays to treatment that might arise as a result of this issue. • Some patients informed us that their eye conditions had deteriorated whilst they were on a waiting list for follow-up appointments.	estimations, as waiting times vary on a day to day basis, written literature would not always reflect an accurate estimation. • Six monthly communications with patients will be undertaken as part of the "Follow-up appointment" project.

What else needs to happen now? The health board needs to continue to discuss with its CHC its eye care developments and its impact on waiting times for people. Patient satisfaction relating to the quality of the information given to patients at clinics in relation to their treatments or any side effects should also be kept under review.	

Hywel Dda University Health Board

What we said needed to get better	Progress reported by the health board
The health board should share the highly positive feedback around: • patients feeling listened to (noting one individual's comments around the perceived attitude of the Consultant and information given) • patients feeling involved in decisions made around their care, but noting the comments of some who did not feel involved • patients receiving full explanations of their condition but again note the comments of one individual who raised concerns • patients being treated with respect, sympathy and with interest • clinical experiences. The health board should consider patient comments and feedback around:	**New ways of working** • To address any "Follow-ups not booked" the health board has established an escalation process via the Ophthalmology validation process to identify whose at highest risk of avoidable harm. This can involve a clinical and administrative review supported by a Primary Care Assessment and can lead to urgent clinics being established where appropriate. This process has now been complemented by the development of **Ophthalmic Diagnostic Treatment Centres** (ODTC) across the region from January 2018. • Since the introduction of an NHS locum consultant in the IVT (Intravitreal injection) clinics, there had been a marked reduction in the number of cancelled clinics. • A primary care refresher has been shared via the Regional Optometric Committee regarding the need to prompt referral to secondary care when necessary. This now forms part of the new Optometric Triage Service, which was introduced in April 2017. **Communication with service users** • The health board has stated that the aim in 2019 is to reduce hospital initiated cancellations, to support this; ○ The health board has established a clear communications plan

• follow-up appointments not taking place on time • cancelled first and follow-up appointments (and operations) • first and follow-up appointments being subject to unreasonable delays. The health board should ensure all patients: • receive enough information to consent to treatments • are advised of what to do if they have any concerns or worries about their condition or treatment The health board should: • Share with primary care providers the need for prompt referral to secondary care. • Primary care providers should ensure that patients feel involved in	to ensure that patients contacting it are contacted promptly to ensure they are seen as soon as possible. ○ A new appointment text reminder service is being explored. • Since the CHC's patient experience review, the health board's Eye Department has established a system with the patient concerns team to immediately contact people to discuss the concerns people have about any delays they are experiencing. It is envisaged that this will be mainstreamed across the health board to include greater contact with the central appointments system. • Revised consent procedures are now in place for IVT and Cataract surgery to ensure that patients are given enough information about the treatment and procedure. This will be audited regularly for compliance. **Community-led services** • As highlighted above, the health board has introduced a community-led service via the opening of ODCTs. A particular function of this is to support the Glaucoma Assessment system (for recurrent community based follow-up appointments). This releases secondary care service and therefore improves timely follow-ups for patients. **Learning from concerns** • The health board advised that it actively looks to learn from concerns

decisions made around their care.	raised and that these concerns are routinely shared in the quarterly **Eye Care Collaborative Group and** Quality Safety & Experience Assurance Committee.

What else needs to happen now?

The health board needs to continue to discuss with its CHC its eye care developments and its impact on waiting times and cancellations. The learning from concerns and complaints should be regularly shared and discussed to make sure this leads to continued improvement.

Powys Teaching Health Board	
What we said needed to get better	**Progress reported by the health board**
The health board should share the highly positive feedback around: • follow-up appointments took place on time and were not subject to unnecessary delays despite some cancellations • the appointments booking process for first appointments but note an individual's comments around cross-border issues • people feeling listened to (noting an individual's comments around attitudes) • feeling involved in decisions made around care • feeling that eye conditions were fully explained • receiving enough information to	**Learning from patient comments** • The health board confirmed that the multiple points of high patient satisfaction were shared within the Mid and South Powys LGM and with operational team members. The health board strives to uphold the standards in the areas highlighted. Some previous comments regarding a consultant's attitude were investigated and the Health Board confirm this doctor no longer visits the Powys area. **New ways of working** • In response to some comments from patients regarding a feeling that a small number of first appointments had been cancelled or delayed, the health board has said it strives to avoid cancelled appointments, but this does sometimes occur for a number of reasons, including the inability of an in-reach consultant (from an external provider) to attend a pre-arranged clinic. **Communication with service users** • In relation to ensuring that patients are offered advice on what to do if they have any concerns or worries about their condition or treatment, the health board has said that this was shared with the operational team members. North Powys LGM responded with details

consent to treatments • peoples clinical experiences • the information received from and feeling listened to by primary care providers. The health board should consider: • patient comments around cancelled first appointments and feelings that these were subject to unnecessary delays. The health board should ensure: • all patients are offered advice on what to do if they have any concerns or worries about their condition or treatment.	of how patient concerns are dealt with by staff, but no further details about this were shared with us. It is important to highlight that the 2016 patient experience review highlighted very high levels of patient satisfaction in multiple areas, except for a few individual comments offered by service users at the time. It is encouraging to report that this high satisfaction was shared throughout the area and individual comments were investigated where possible.

What else needs to happen now?

The health board needs to share and discuss with its CHC its patient experience feedback and measures to make sure the positive experiences shared by most patients continue.

Swansea Bay University Health Board

What we said needed to get better	Progress reported by the health board
• Consider the Patient feedback in relation to cancelled follow-up appointments and Patient views that some first appointments and follow-up appointments are subject to unnecessary delays. • Share the positive feedback that Patients did feel listened to and felt involved in decisions made around their care by the Secondary Care health professionals. • Share 100% positive feedback that patients felt their conditions were explained fully and in a way they could understand. • Ensure that all patients are informed of what to do if they have any concerns or worries around their condition or treatment. • Share the highly positive patient feedback around inpatient	**Community-led services** • A Glaucoma service is now provided within the Swansea area to assist in offering patients appointments that are closer to home and avoiding the need to attend a hospital setting for appointments. **New ways of working** • To ensure adequate service provision within the hospital setting for clinics and appointments and in order to avoid delays or cancellations, the Directorate now undertakes 6-week annual leave monitoring to ensure adequate provision. Any leave requested by clinicians with under 6 weeks' notice are only sanctioned in special circumstances. • The health board is aiming to recruit additional practitioners to release doctors for urgent or specialist clinics. It is hoped that this will also reduce clinic cancellations. • The health board has also gained 2 additional rooms this year due to the relocation of the Diabetic Screening Service, which has enabled it to increase capacity and also increase the number of Vision Lanes in the department. • The health board acknowledges that current delays in the service are due to a lack of capacity to meet demand. It says that plans are in

experiences. • Share with primary care providers the patient feedback around offering adequate information/explanation to patients about the suspected problem with their eyes and ensuring that all patients feel listened to and involved in decisions made around their care.	place to address the backlog, such as recruitment etc. **Communication with service users** • People who may have concerns or worries about their condition or treatment are directed to the hospitals PALS (Patient Advice and Liaison) team via posters within the eye department. • To ensure that patients are adequately informed of the reasons for their referral into secondary care services, feedback was delivered to Primary Care providers via their cluster group meetings. This work will also form part of the role of the Optometric Advisor who has been in post since 2016.

What else needs to happen now?

The health board needs to share and discuss with its CHC the detailed plans it has in place to address long waiting times, as well as its action to address concerns about what people should do if they have worries about their condition or treatment.

Are people still waiting too long for appointments?

We looked at the information published by the Welsh Government to see if the action taken by health boards is leading to improvements in how long people have to wait for their care and treatment.

The table below shows that between April 2016 and March 2019 things got better for people waiting for their first appointment. Less people waited over 36 weeks.

	Waiting up to 26 weeks	Waiting between 26 to 36 weeks	Waiting over 36 weeks
2016/2017	80%	13%	7%
2017/2018	80%	15%	5%
2018/2019	84%	14%	2%

All-Wales eye care measures

Since April 2019 the Welsh Government has been monitoring the performance of eye care services against new measures[3].

The measures identify performance for first appointments (new) and appointments for people who need on-going care and treatment for their eye conditions (follow-up).

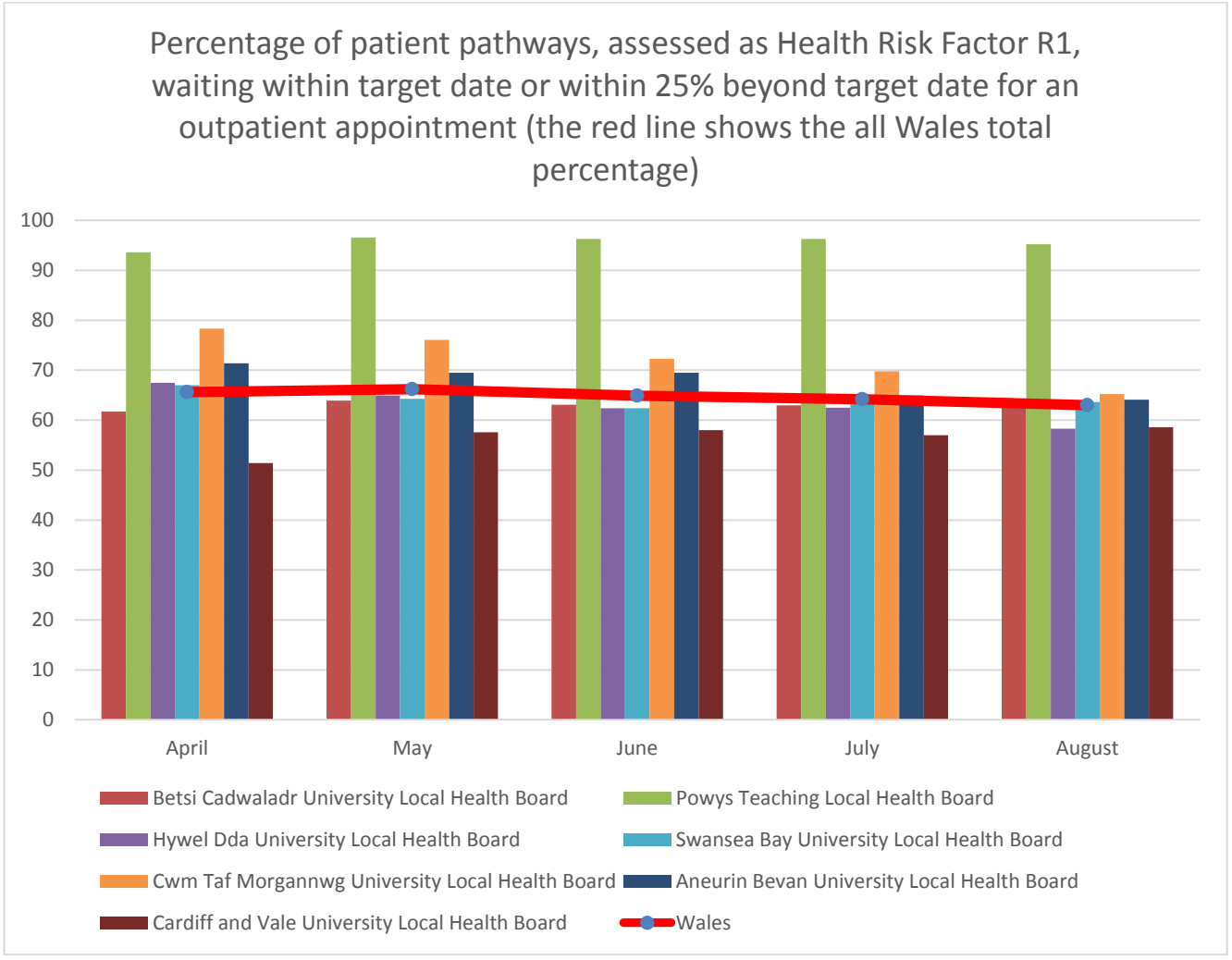
Target dates for appointments are based upon clinical assessments of peoples' condition and well-being. The measures track how well NHS bodies are performing for people who are assessed as being "at **risk**

[3] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Eye-care/eyecaremeasuresfornhsoutpatients

of irreversible harm or significant adverse outcome[4]" if they are not seen within their target times.

The table and graph below show the performance across Wales since the introduction of the new measures.

	April 2019	May 2019	June 2019	July 2019	August 2019
Total number of people assessed as Health Risk Factor R1	100,223	104,095	109,021	110,735	113,132
Number and % of people above waiting within their target date[5]	65,703 65.6 %	68,908 66.2 %	70,798 64.9 %	71,044 64.2 %	71,278 63 %



[4] Health Risk Factor R1

[5] Or within 25% beyond target date for an outpatient appointment

The way the figures are presented means it's not clear what proportion of people are waiting within their target times or outside that target time by within 25%. Neither is it clear what being outside that target time but within 25% may mean in terms of potential harm.

What the figures do show is that around a third of people identified as being at risk across Wales if they are not seen within their target times have waited too long for their appointment.

There are differences in performance in different parts of Wales. People living in Powys were more likely to be seen within their target times than people living in other parts of Wales.

Aneurin Bevan, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards have seen their performance get worse against the targets between April and August 2019.

Aneurin Bevan, Cwm Taf Morgannwg and Hywel Dda Health Boards have seen a significant increase in demand during the same period (as shown in the graph below).

Betsi Cadwaladr, Cardiff and Vale University Health Boards and Powys Teaching Local Health Boards have improved their performance over the same period.

	April 2019	August 2019
Aneurin Bevan	11,539	16,053
	71.5 %	**64.1 %**
Betsi Cadwaladr	29,519	29,666
	61.7 %	**63.5 %**
Cardiff and Vale	16,133	16,150
	51.4 %	**58.6 %**
Cwm Taf Morgannwg	15,896	19,719
	78.3 %	**65.2 %**
Hywel Dda	9,351	12,636
	67.5 %	**58.3 %**
Powys	1,102	1,426
	93.6 %	**95.5 %**
Swansea Bay	16,683	17,482
	67 %	**63.6 %**

Number of people	Percentage of people

Summing up

Too many people are still waiting too long to access the eye care services they need. According to the Welsh Government's new measures this means that, in August 2019, over 40,000 people in Wales were at risk of "irreversible harm or significant adverse outcome" as a result.

Since our 2016 review each health board has demonstrated a real commitment to improving eye care services in their area.

Many of the health boards were also clear about their continued concerns about delays in on-going (follow-up) appointments. All health boards have been taking action, and most have set out how they plan to address the continuing delays.

These plans have not yet led to a better service for far too many people.

Some of the actions already taken by health boards have clear benefits for people. For example, the introduction of community-led services means people can get to their appointments closer to home. The extended roles of eye-care professionals is also appearing to help release consultant capacity.

However, based on the responses provided by each health board and in view of the published performance figures, more clearly needs to be done so that people in Wales get the eye care treatment they need when they need it.

The Welsh Government and the NHS in Wales needs to:

- do more to reduce the current backlog of people waiting for appointments
- make sure longer term plans are capable of providing an equitable service that meets the increasing demand for eye care services across Wales
- provide people with the information they need to support their knowledge and understanding of their condition and treatment options.
- Make sure there are robust patient feedback arrangements in place to regularly monitor and review patient satisfaction
- Make sure digital communication moves forward at pace in all areas.

In response, the Welsh Government told us that:

"When introducing the new measure, we were aware that it would be a number of months before sustainable improvements may be noted. To support health boards, a sustainability fund of £3.3 million was made available to implement optimum pathways and establish community led services.

We are assured this funding, supported by additional capacity from primary care optometrists, will improve waiting times going forward in all areas."

CHCs will continue to monitor NHS performance in their health board areas to check whether improvements are made where needed in all parts of Wales.

Acknowledgements

We thank all 7 health boards in Wales for their prompt responses to the Community Health Council's request for information.

Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it.

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