WHC (2014) 007/14

WELSH HEALTH CIRCULAR

Issue Date: 12 November 2014

Llywodraeth Cymru
Welsh Government

STATUS: COMPLIANCE

CATEGORY: HEALTH PROFESSIONAL LETTER

Title: Wales Eye Healthcare Service - Eye Health Examinations Wales (EHEW)

Date of Expiry / Review: n/a

For Action by:
All accredited EHEW Optometrists

Action required by:
Immediate

Sender: Sarah O'Sullivan-Adams, Head of Audiology and Ophthalmic Policy

DHSS Welsh Government Contact(s) :
Sarah O'Sullivan-Adams, Audiology and Ophthalmic Policy Branch, Health Policy Directorate, Welsh Government, Cathay's Park, Cardiff, CF10 3NQ, Contact Telephone Number 02920823998

Enclosure(s): Eye Health Examination Wales (EHEW) Service – A clinical manual with protocols for optometrists and ophthalmic medical practitioners (OMPs)

Dr Barbara Ryan
Chief Optometric Adviser/Prif Optometrig Ymgynghorol
Directorate for Public Health
/Y Gyfarwyddiaeth dros Iechyd y Cyhoedd
Department for Health, Social Services and Children/
Yr Adran Iechyd a Gwasanaethau Cymdeithasol

Llywodraeth Cymru
Welsh Government

Date: 12 November 2014
Our ref: WHC/007/14

Dear Colleague,

Eye Health Examination Wales Service

In 2013 the Eye Health Examination was revised and a banding structure implemented. A review of the service one year on was informed by a clinical audit, service data and a consultation with service providers.

The biggest change to the service last year was the introduction of the Band 2 which enables practitioners to conduct further investigations/ examinations to inform or prevent onward referral to the hospital eye service. The audit found that 81% Band 2 patients were managed in practice which demonstrates the value of this additional element of the service.

The review also demonstrated areas were the guidelines or protocols were not clear and/ or the service could be improved. Therefore, a revised EHEW manual V2.2014 has been produced in consultation with the professional bodies and will be issued to all registered EHEW practitioners in Wales from 1 November 2014. An electronic copy of the manual will be issued at the same time. When you receive it please insert the new manual and appendices into the previous EHEW folder. Please ensure all previous paperwork issued is disposed of. The current Wales Eye Care Service (WECS) forms (WECS 1, 2, 3 and 4) are unchanged and should be retained.

Please read the new manual really carefully. There have been a lot of changes and it is important that you work to the new guidance and protocols from 15th December 2014. The main changes or areas of clarification that I would like to draw your attention to are:

- Some things have been changed from guidance to a protocol. These elements must be done in order to claim payment and will be audited.

- The family history category has been removed from Band 1. This is in response to the data showing no tangible benefit to public health outcomes as well as a low uptake. These patients are eligible for a GOS examination. If further investigations are necessary to prevent or inform a referral following a GOS examination, then a Band 2 could be performed.

- Going forward, you need to ensure that the reason for the EHEW examination is recorded clearly on the notes.

- A report must be written to the patient's GP following every EHEW.

Ffon/Tel: 029 2082 3505
Parc Cathays, Caerdydd CF10 3NQ
Cathays Park, Cardiff CF10 3NQ
Ebost/Email:barbara.ryan@wales.gsi.gov.uk

- In cases where there is no pathology noted to refer, claims would not normally be allowable for pupil dilation e.g. it would not be permitted to claim a band 2 simply because the patient had miosed pupils. Similarly, additional investigations which are not explicit in the EHEW guidance such as pachymetry or OCT would not be seen as a reason to claim.

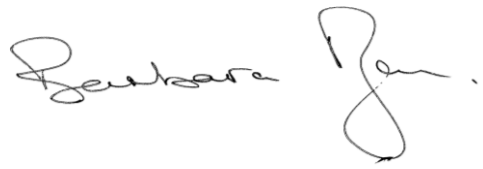
- VA and whether dilatation was conducted should be recorded on all EHEW records.

- There is clear guidance on what referrals for different conditions should include.

Further information can be found in the service guidance or at www.eyecare.wales.nhs.uk. If you have a question about the service please contact WECS@cardiff.ac.uk.

The service is going from strength to strength and is increasingly valued by the public and other health care professionals.

Yours sincerely



Dr Barbara Ryan
Chief Optometric Advisor

Eye Health Examination Wales (EHEW) service

A clinical manual with protocols.
For optometrists and ophthalmic medical practitioners (OMPs).

Issued by the Welsh Government for the NHS Wales. Version 9 – July 2014.

Service Information
Protocols
Clinical Guidance

Cataract
Glaucoma & Ocular Hypertension
Age-related Macular Degeneration
Retinal Breaks & Detachments

This manual and the protocols were produced in consultation with Welsh Government, Optometry Wales (OW), the Welsh Optical Committee (WOC) and the Clinical Lead for EHEW.

This manual is not meant as a replacement for Optometrist or Ophthalmic Medical Practitioner (OMP) professional judgment or responsibility.

For the most up-to-date version and further information, please go to: www.eyecare.wales.nhs.uk

For further information about courses, training and assessment for the EHEW service go to: www.wopec.co.uk

For all comments or questions, please contact WECS@cardiff.ac.uk

Archwiliadau Iechyd Llygaid Cymru
Eye Health Examination Wales

INDEX

Service Information

The Eye Health Examination Wales (EHEW) is part of the Wales Eye Care Service (WECS). WECS is inclusive of the EHEW, Low Vision Service Wales (LVSW) and the Diabetic Retinopathy Screening Service Wales (DRSSW).

The EHEW is an extended eye care service which is free at the point of access for patients. This manual outlines a structure allowing optometrists or OMPs to provide the EHEW service.

Local pathways agreed between Health Boards and Regional Optometrist Committees/ Optometric Advisors may exist and practitioners should ensure that they are aware of these and any protocols arising from them separately from this manual.

This manual is subject to regular updates according to the needs of the service. Any updates will be sent electronically to every optometrist or OMP providing the service.

1.0 How the service works

- Optometrists or OMPs must be accredited to provide the service and subsequently re-accredited every 3 years to continue as a provider. Training, accreditation and re-accreditation is provided by the Wales Optometry Postgraduate Education Centre (WOPEC) under contract from the Welsh Government.
- Optometry practices must be registered to provide EHEW services. Payments made to optometric practitioners and OMPs are co-ordinated by the NHS Wales Shared Services Partnership (SSP) and subject to post-payment verification (PPV) according to protocol as agreed between NHS Wales and the professional negotiating body (Optometry Wales).
- The WECS 1 payment form (see Appendix I) will provide data for payment verification and audit. This data is held in a secure data-management system by the SSP.
- Clinical audits will be regularly carried out and participation is automatically agreed as part of the optometrist or OMPs training to provide the EHEW service.
- Practices providing EHEW must be able to offer appointments to anyone who is eligible to access the service.
- A banded fee structure applies for the EHEW service.

Enquiries:

- For clinical, audit, registration or accreditation enquiries please contact the EHEW Clinical Lead (029 20 876988) or WECS@cardiff.ac.uk
- For payment enquiries please contact your local NHS Wales Shared Services Partnership (SSP). For South East and North Wales, contact Ophthalmic.SE@wales.nhs.uk. For Mid & West Wales contact Domiciliary.visits@wales.nhs.uk.

The following pages contain protocols which must be met, specifically for payment purposes.

Guidance included is to be followed when appropriate wherever possible.

A practice must be able to offer an appointment to anyone entitled to use the service. This is part of the service level agreement and must be adhered to except in exceptional circumstances.

To receive payment for an EHEW examination the following conditions must be met.

2.0 General Protocol for EHEW

Registration

1. The practice where the EHEW takes place must be registered to provide EHEW (see Section 1.0 for details).

2. The optometrist or OMP performing the eye examination must be accredited to provide EHEW.

Forms

3. All sections of the WECS 1 form must be completed.

4. The patient must sign and date part 1 of the WECS 1 form as instructed.

5. The optometrist must sign and date part 2 of the form as instructed. The contractor must sign and date part 2 of the form. If the EHEW has been conducted by the contractor, only one signature is required at the bottom of this form.

Examples of all the WECS forms can be found in the Appendices.

Record Cards

6. The patient record card kept in a practice must clearly state the reason for the EHEW being performed.

Referrals/ Reports

7. A report must be written to the patient's GP (normally sent within 7 days) after

every EHEW examination.

8. A WECS 3 form or a practice letter containing all details specified in the Notes below* should be used for all referrals to a secondary care hospital following an EHEW except where alternative national referral templates exist – e.g. Age Related Macular Degeneration (ARMD) form.

9. A WECS 2 should be used or the template provided for all notification reports to the GP following an EHEW.

*Notes: If a practice letter/ proforma rather than the WECS forms are used then they must contain:

- The NHS Logo at the top of the letter (applications to obtain the Logo can be obtained from the clinical lead for EHEW).
- What type of form it is; either WECS 2, 3 or 4.
- Use the exact same headings at the top of letter. For WECS 2 -GP INFORMATION FORM: (NOT for referral to Ophthalmology). For WECS 3 - Referral: Optometry to Ophthalmology
- The practice letter must contain all other information found in the WECS 2, 3 and 4 forms and these must be filled in with the appropriate information.

Claims

10. A Band 2 EHEW must follow a GOS or private eye test only*.

11. A Band 3 EHEW must follow a Band 1 only*.

12. Only one Band 2 EHEW can be claimed per patient per year*.

13. Only one Band 3 EHEW can be claimed per patient per year.

14. An EHEW cannot be claimed for a domiciliary visit.

* Unless there are other pathways agreed by your Health Board.

Further advice about filling in the WECS 1 form claim can be found in Section 9.0.

Equipment

15. Contact tonometry (a Goldmann or Perkins) must be used for all measurements of Intraocular Pressure (IOP), unless the patient would come to harm by doing so.

3.0 Eye Health Examination Wales (EHEW) - BAND 1 General Information

Band 1 EHEW examinations enable patients with acute eye conditions, those in at-risk categories for developing eye disease, or those who would find losing their sight particularly difficult to obtain a free at the point of access eye examination. The full list of eligibility is below:

1. Patient experiencing an eye problem that requires urgent investigation, (including self referral or referral from another healthcare practitioner).
2. Patient at risk of eye disease by reason of ethnic group (Asian or Black).
3. Uniocular patient
4. Patient has a Hearing impairment
5. Patient has Retinitis Pigmentosa (RP)
6. Referral by another eye care professional (e.g. GP/ secondary care hospital ophthalmologist)
7 Needs investigations to comply with WG agreed protocols:
   - 7a. Referral by DRSSW
   - 7b. Dry AMD monitoring
   - 7c. Pharmacy Common Ailment Scheme

Note that the following are not included and as such are NOT eligible categories:

- Chronic dry eye
- Contact Lens wearers who receive their contact lens care through the practice and who present with a red and/or sore eye that is a contact lens related problem or pathology.

3.1 Band 1 Protocol

A Band 1 can only be claimed if at least one of the above criteria is met and this reason is ticked and/ or annotated on the WECS 1 form.

Regarding each reason for a Band 1:

1. Only if a patient presents with an eye problem or symptoms that need urgent investigation can a practitioner submit a claim on this basis. The type of symptom or eye problem and how long since it began should be stated clearly on the patient record card. The patient should be offered an appointment within 24 hours in line with the agreed training and accreditation protocol.

2. The patient must self-certify, by ticking the appropriate box in Part 1 of the WECS 1 form, that they are either Asian /Asian/British or Black/African/Caribbean/Black British before a claim can be submitted on the basis of ethnic group.

3. The uniocular category may only be used for those patients who would be eligible for registration as Sight Impaired if they lost vision in their 'good' eye.

4. A patient must self-certify that they are significantly hearing impaired before a practitioner can submit a claim on this basis.

5. Patients must be diagnosed as having retinitis pigmentosa by an ophthalmologist in order for a claim to be made on this basis.

6. A referral into the EHEW service can be made by a GP (this may be an acute or chronic eye related problem), ophthalmologist, or other health care professional.

7. When a patient has been referred by the DRSSW service, a WECS 4 form (see Appendix IV) must be used to report the findings back to DRSSW. For dry AMD monitoring see the Clinical guidance Section on AMD. For the Pharmacy Common Ailment Service refer to the local agreed protocols.

3.1.2 Refraction

If a Band 1 examination is carried out because of an acute eye problem then a refraction is not usually necessary, unless it may help determine the nature of the acute eye problem (e.g. headaches or diplopia).

If the Band 1 examination is for any other reason then a refraction must be carried out as part of the examination and a private prescription can be issued. An NHS voucher (GOS 3W) may be issued if the patient is eligible. If a GOS3W voucher is issued following refraction, as part of the Band 1, it must be issued from the private prescription (not a GOS 2W). Since refraction is expected then all the required components of a sight test as defined by the GOS terms of service should be included.

3.2 Band 1 Guidelines

Normally, only one Band 1 can be claimed per year per patient. However, in exceptional circumstances a further EHEW can be performed. The usual safeguards regarding decision-making apply and the relevant reasons and circumstances must be recorded in the clinical records. Examples include:

- A patient has had an EHEW for reasons of ethnic group but returns experiencing eye problems that need urgent attention shortly afterwards. They would be entitled to a further EHEW under the category of an eye problem that needs urgent attention
- A patient has an EHEW Band 1 at the first visit for an acute red eye and then returns 2 months later with an unrelated clinical episode of flashes and floaters. The second visit would also be eligible for a Band 1.
- A patient has a red eye in their right eye on the first visit but returns later with different symptoms and a red eye in the left eye. This would be considered as two different clinical episodes and therefore a Band 1 can be claimed at both visits.

4.0 Further investigation/ examinations - BAND 2

These examinations enable patients to have additional investigations. They can only be used to further inform or prevent onward referral to the hospital eye service.

4.1 Band 2 Protocols

1. A Band 2 EHEW only follows a GOS or private eye test.*

2. Only one Band 2 EHEW can be claimed per patient per year.*

3. A claim cannot be submitted for a Band 2 for pupil dilation to afford a better view of the fundus.

4. To claim a Band 2 for investigation of suspect Glaucoma/ Ocular Hypertension (OHT) you must carry out 2 IOP measurements using a Goldmann or Perkins. If threshold related visual fields are abnormal, they must be repeated before referral.

5. Pre-operative assessment of a patient with cataract must include dilated fundus examination and patient counselling (including administration of a questionnaire).

* Unless there are other pathways agreed by your Health Board.

4.2 Band 2 Guidelines

The following are guidelines about investigations that would, or would not be allowable for an EHEW:

<u>What would normally be allowable for a Band 2:</u>

- Cycloplegic refraction of a child.
- Wide field (e.g. 60 degrees) threshold related visual field examination for unexplained headaches.
- Repeated IOP and visual fields to inform whether a patient should be referred with suspect glaucoma.
- Macular conditions where additional examinations are carried out to determine the nature of the problem and whether referral is required.

<u>What would not normally be allowable for a Band 2:</u>
In cases where referral is not otherwise indicated the following **would not normally be allowed:**

- Dilation of the pupil to get a better view of the fundus.
- OCT.
- HRT.
- Pachymetry.
- Fundus photography.

- Syringing or punctum plugs for dry eye.
- Gonioscopy.

Note that whilst these are not allowable in isolation, if they are used as part of referral refinement or management alongside other investigations, then it is acceptable i.e. those listed are not allowable on their own as a Band 2 but may be used as an addition to other investigations.

A Band 2 would normally be carried out on the same day as a GOS or private sight test but may be carried out on a different day according to patient or clinical needs.

Examples where the patient may need to be bought back include:

- Dilation and Volk BIO, Goldmann/ Perkins tonometry and threshold related test of visual fields for a patient with suspect glaucoma/ OHT would need to be repeated following an initial visit before a Band 2 can be claimed.
- Cycloplegic refraction of a child (this may need to be done on a different day)
- The patient brought back for threshold related testing visual field examination for unexplained headache.

5.0 EHEW follow-up examination – Band 3

A Band 3 examination enables a patient to be followed-up after they have had an initial appointment for an EHEW Band 1. The appointment would be made on different day and usually would be a short term follow-up appointment.

Follow-up examinations may be used at the discretion of the optometrist or OMP to include any procedures they feel are clinically necessary.

5.1 Band 3 Protocol

1. A Band 3 follows a Band 1 only*.

2. Only one Band 3 EHEW can be claimed per patient per year.

* Unless there are other pathways agreed by your Health Board.

5.2 Band 3 Guidelines

Examples of an EHEW in the category of a patient experiencing an eye problem that requires urgent investigation (Band 1) which subsequently may require a follow-up (Band 3) appointment include:

- Review of patient with unresolved symptoms of flashes and floaters
- Re-assessment of a patient with marginal keratitis
- Re-assessment of a patient with corneal abrasion
- Re-assessment of a patient with foreign body
- Re-assessment of a patient with a non-resolving red eye
- Corneal lesions of unknown origin follow-up

6.0 What the examinations involve

6.1 EHEW

If a patient presents with an eye problem that requires urgent investigation then the level of examination should be appropriate to the reason for referral and procedures are at the discretion of the optometrist or OMP. Note that Intra-Ocular Pressure must always be measured with Goldmann or Perkins tonometers.

The optometrist or OMP must, be able to offer an EHEW on the day that it is requested or within 24 hours of the request from the patient or G.P where the patient is experiencing eye problems that need urgent attention.

If the patient is eligible for an EHEW in one of the 'at risk' or 'would find losing their sight particularly difficult' categories or due to referral from another eye care professional (e.g. GP/ secondary care hospital Dr/other optometrist) then the following procedures are mandatory for an EHEW, in most cases:

- Refraction (see 3.1.7)
- Visual acuity measurement
- A slit lamp examination of the anterior segment
- An assessment of the anterior chamber angle
- Contact tonometry using a Goldmann or Perkins tonometer
- A dilated fundus examination using a slit lamp and a Volk lens (unless an excellent view is seen without dilation, in which case this must be annotated on the record card)
- A threshold related visual field examination, from which a quantifiable field printout is available
- Other procedures at the discretion of the examining optometrist or OMP

If there is a reasonable and legitimate reason for omitting a procedure then it must be annotated in the patient record card in the practice before an EHEW claim may be made.
For example

- A patient who has an anterior iris clip lens that prevents dilation of the pupil or
- A patient who is being monitored for moderate AMD where visual field examination is not clinically necessary.

If refraction with an intention to prescribe is included, then the episode would be deemed a sight test by the GOC and therefore all necessary components of a sight test should be included.

7.0 Equipment required in practice

The minimum level of equipment should include:

- Slit lamp
- Volk, or similar lens for Binocular Indirect Ophthalmoscopy (BIO)
- Contact tonometer (Goldmann or Perkins)
- Automated visual field equipment capable of producing a field plot print-out and threshold related examinations
- Eyelash removal instruments
- Foreign body removal instrumentation
- Direct Ophthalmoscope
- Amsler charts
- Diagnostic drugs
- Retinoscope
- Vision testing equipment suitable for testing children

8.0 Referrals

All referrals should normally record the following information:

1. Relevant history and symptoms
2. Relevant general health
3. Medication (dosage and when taken, if known)
4. Vision or Visual acuities
5. Significant signs found
6. An indication that other findings were normal
7. Diagnosis alluded to or given
8. Action required
9. Urgency of referral

8.1 Detail and urgency of referrals

Onward referrals for <u>suspect glaucoma / OHT</u> should record the following:

1. Description of optic disc including C/D ratio.
2. Intraocular pressure (IOP), including time of day, using a GAT/ Perkins tonometer.
3. Threshold related Central visual field plot from an automated perimeter capable of producing a print out (e.g. Humphrey.)
4. Slit lamp assessment of anterior eye.
5. Anterior chamber angle assessment (e.g. Van Herick).

Referral letters for patients with <u>AMD</u> should include the following information:

1. Visual acuities.
2. A clear indication of the reason for referral.
3. A brief description of any relevant history and symptoms including onset.
4. Description of the macula noting the presence of:
   a Macular drusen
   b Pigment epithelium changes (hyper/ hypo pigmentation)

c Retinal thickening (oedema and exudates)
d Signs of sub- retinal neovascular membrane
e Sub-RPE or sub-retinal fluid
f Sub-RPE, sub-retinal, intra-retinal and pre-retinal haemorrhages

Patients requiring referral for cataract must have the following noted in the referral letter to the ophthalmologist:

- A clear indication of reason for referral as a title for the referral
- That the patient is willing to consider surgery
- Visual Acuity now and what it was previously (including date of previous VA)
- Pinhole VA, if appropriate
- Confirmation that the cataract is main cause of sight loss
- Notification of any co-existing ocular pathology
- Confirmation that the patient's lifestyle and/ or quality of life is compromised as a result of the cataract
- The referred eye for surgery
- Previous history of cataract surgery or refractive surgery
- A list of any medications taken by the patient
- A copy of the questionnaire should be sent with the referral.
- The presence or absence of AMD

When necessary other relevant information should be supplied (e.g. cover test and motility for a binocular vision related referral). Relevant family history should always be included where applicable. For specific conditions, please refer to the clinical guidance section. If the referral is to the GP, spectacle prescription is not necessary. Referrals should be sent direct to the most appropriate professional.

Referrals to ophthalmologists will be sent direct and **not** via the GP.

9.0 Filling in forms

Information on the WECS 1 form will be used for the purposes of clinical audit.

Post payment verification checks will be carried out to ensure the EHEW manual protocols and guidelines are followed.

By signing the WECS 1 form you are signing that you understand and accept that if you withhold information or provide false or misleading information, you may be liable to prosecution and or civil proceedings.

You are confirming that you are entitled to perform an EHEW eye examination and consent to the disclosure of relevant information for the purpose of checking this; planning and administering the service; and in relation to the prevention and detection of fraud. You are also agreeing to pay back the cost of the service if later found not to be entitled to it.

You should sign and date only the forms relating to the examinations which you have provided. You should sign them at the time of dealing with the patient. Never sign blank WECS forms. If they are subsequently submitted fraudulently and they have your signature, then you may be held responsible and could be accused of fraud. This is of particular importance to those practitioners who do locum work.

Note the following **protocols** related to form filling:

1. All sections of the WECS 1 must be completed.

2. The patient must sign and date part 1 of the WECS 1 form as instructed.

3. The optometrist must sign and date part 2 of the form as instructed. The contractor must sign and date part 2 of the form. If the EHEW has been conducted by the contractor, only one signature is required at the bottom of the WECS 1 form.

9.1 Part 1. – Patient's Details and Declaration

Patient name, address, date of birth and the Doctor's (GP) name and address can be filled out by the patient, the practitioner or a member of practice staff.
The patient /guardian (not the optometrist or OMP) must fill in their ethnic group. Ethnicity is required so that the optometrist can decide if they are at risk of eye disease because of their ethnicity (see 9.3 below). The information is also used to determine what ethnic groups are accessing the EHEW service.

Patients themselves should indicate their ethnic background and then sign and date Part 1 of the WECS 1 form before the eye examination.

9.2 Part 2. – Optometrist/ OMP Declaration

For Part 2 of the WECS 1 form the optometrist or OMP is required to declare the reason for examination and date when the examination took place.

9.3 Band 1: Eye Health Examination Wales (EHEW):

<u>Has an acute eye problem</u>
Only if a patient presents with an eye problem or symptoms that need urgent investigation can practitioner submit a claim on this basis. The type of symptom or eye problem and how long since it began should be stated clearly on the patient record card. The patient should be offered an appointment within 24 hours. This is in line with the agreed training, accreditation and protocols.

<u>Is Uniocular</u>
The uniocular category is for patients who would be eligible for registration as Sight Impaired if they lost their 'good' eye.

<u>Is hearing impaired</u>

A patient must self-certify that they are significantly hearing impaired before a claim can be made on this basis.

Has RP
Patients must be diagnosed as having retinitis pigmentosa by an ophthalmologist in order for a claim to be made on his basis.

Was referred by a Dr
Any patient who is referred at the request of a GP (this may be an acute or chronic eye related problem), ophthalmologist, pharmacist or other health care professional.

Is at risk of eye disease due to ethnic background
Epidemiological research has shown that a patient with an ethnic background that is Eastern, South Eastern or Southern Asian or Black/African/Caribbean are at greater risk of Diabetes Mellitus and Glaucoma compared to White or other ethnic groups, including those of mixed ethnicity. Therefore, patients that have confirmed they belong to these ethnic groups (and by association those who are Asian British or Black British) are at greater risk of sight threatening eye disease and are eligible for a Band 1 EHEW.

The patient must self-certify by ticking the appropriate box in Part 1 of the WECS 1 form that they are either Asian/Asian British or Black/African/Caribbean/Black British before a claim can be submitted on this basis. Where currently there is no box for Ethnic groups in South, South East or East Asia the 'other' ethnicity box should be ticked and the ethnic group annotated.

Needs investigation to comply with WG agreed protocols/ guidelines
Any patient with an eye problem not related to diabetes picked up in DRSSW screening will be referred to an EHEW accredited optometrist. This should be annotated on the WECS 1 form in the specify section as 'DRSSW'. A report to the DRSSW on a WECS 4 form should be completed and sent to DRSSW within 7 days.

Any patient with Dry Macular Degeneration or non-treatable Wet Macular Degeneration may be monitored every year as an EHEW Band 1 because of the risk of further Wet AMD changes. This should be annotated on the WECS 1 form in the specify section as 'AMD'.

Any patient referred from a local Pharmacy using the Common Ailment Service should be seen as per the agreed protocol.

9.4 Band 2: Further investigations/ Examinations

Band 2 enables the optometrist or OMP to further inform their referral, investigate clinical findings or determine management following a GOS or private sight test only.

This category is not to be used following a Band 1 EHEW examination.

9.5 Band 3: EHEW Follow-up

After a Band 1 EHEW, an optometrist or OMP may need to see the patient again on another occasion (not the same day) to ensure the patient is being clinically managed in the most appropriate way.

A Band 3 EHEW is to be used at the discretion of the optometrist or OMP to include any procedures they feel are clinically necessary.

Only one Band 3 EHEW follow up claim can be submitted per patient in a single calendar year.

The date of the Band 3 EHEW follow up examination should be filled in.

9.6 Audit and clinical information guidance

Optometrists or OMPs must ensure they have entered at least one tick in all the sections on the back of the WECS 1 form. This is essential for clinical audit of the service. If it is not filled out payment may be withheld pending investigation. To facilitate clinical audit please tick all that apply about the symptoms prior to the examination and/ or the findings following the examination. It may be that multiple boxes need to be ticked.

9.7 I took the following action

This section is to determine the patient management following the EHEW examination. Please note that the patient's GP must be informed following all EHEW examinations (Band 1, 2 and 3) and the report to the GP should be completed and sent to the GP within 7 days.

9.8 Signatures

The optometrist or OMP who conducted the EHEW examination should sign to state they have conducted the examination, indicating the date on which the examination took place and giving their Ophthalmic or Supplementary Ophthalmic List number.

The contractor, or his/her/its authorised signatory, should sign and date the claim section. If the EHEW has been conducted by the contractor, he/she need sign only the claim section.

9.9 Resident in Wales

You may offer a Band 1 EHEW to any person not ordinarily resident in Wales who has symptoms or an eye problem requiring urgent attention which cannot be reasonably delayed until the person returns to their home (similar to a patient visiting a GP practice for a health emergency as a temporary resident). It is a matter for your professional judgement to determine whether an EHEW is immediately required for the symptoms or eye problem in each individual case.

Delegation

Tasks can be delegated, but must be supervised (i.e. optometrist on the premises and available in case of problems). Delegation relates only to the performance of the task (such as visual field testing), not the interpretation of the results. The College of Optometrist guidelines state 'The optometrist has a duty to ensure that the patient receives the same standard of care whether or not s/he delegates any task and to satisfy him/herself as to the competence and suitability of the person to perform the task being delegated'. For more information refer to the College Guidelines: www.college-optometrists.org/en/professionalstandards/Ethics_Guidance/recent.cfm

Where pre-registration optometrists perform the first examination of patients who are eligible for an EHEW examination, the primary supervisor must be on-site and must personally check all aspects of the examination and findings to be able to claim an EHEW examination fee. In a case of a red eye, the supervisor would always be expected to perform slit lamp of the anterior segment. In the case of flashes and floaters the optometrist would be expected to always check the retina and anterior vitreous.

Clinical Guidance section

Glaucoma & Ocular Hypertension
Age-related Macular Degeneration (AMD)
Retinal breaks & detachments
Cataract

Glaucoma and Ocular Hypertension

The assessment and management of patients with glaucoma, suspect glaucoma or ocular hypertension (OHT).

1.0 Definitions

1.1 Glaucoma

An optic neuropathy in which there is progressive, characteristic loss of the neuro-retinal rim tissue, which can be slowed or arrested by a reduction in IOP. Under current National Institute for Clinical Excellence (NICE) guidelines, glaucoma may only be properly diagnosed by a consultant ophthalmologist.

1.2 Ocular hypertension (OHT)

Consistently or recurrently elevated IOP (greater than 21 mm Hg) in the absence of clinical evidence of optic nerve damage or visual field defect.

2.0 Assessment

2.1 History

In addition to a normal history and symptoms, the following history should be ascertained:

The following history findings are risk factors for glaucoma:

- Age - Increasing prevalence of open angle glaucoma with age increases dramatically over 75 years. Also there is an increased risk of angle closure glaucoma with increasing age.
- Race - Black, Oriental Asian (normal tension glaucoma), Asian (angle closure)
- Family history - 1st degree relative. Especially siblings (open angle)
- Refractive error -Myopia (open angle), hypermetropia (angle closure)
- General health - vasospastic disorders, e.g. migraine or Raynaud's Syndrome (open angle)
- Gender - Females are at greater risk of angle closure

2.2 Symptoms

Open angle glaucoma is a slowly progressing, insidious disease and most patients will not have symptoms until the latter stages when they may report bumping into things (particularly at night) or dynamic objects disappearing from their vision fleetingly.

All patients must be examined in case they are at risk of Primary Angle Closure Glaucoma (PACG) by viewing the anterior angle by Van Herick and/or Redman-Smith and/ or gonioscopy.

Patients with PACG may have acute, transient or no symptoms at all. If present, symptoms may include:

- Brow ache or an intense ache around the eye socket in one eye, particularly in dim illumination (physiological pupil dilation) or when experiencing excitement or fear (psychological dilation of pupils)
- Haloes around light sources or rainbow effect around point sources of illumination
- Nausea
- Blurred vision

2.3 Examination

Tonometry methods

For measuring IOP, Goldmann Applanation Tonometry (GAT) or Perkins are considered most accurate by NICE. GAT/ Perkins should be carried out on two separate occasions before onward referral.

All tonometers should be fully functioning and accurate – calibration should be carried out every 4 weeks for GAT and Perkins to ensure continued accuracy. It is good practice to keep a record of undertaking calibrations.

Visual field examinations

The sensitivity and specificity of visual field tests for detecting glaucoma can be improved by repeated testing. Visual field examinations should be carried out on two separate occasions before onward referral, unless the first visual field result is normal in which case only one visual field is necessary.

A threshold related suprathreshold examination of the visual field is suitable for referral purposes provided a print out can be obtained.

Anterior segment and Van Herick's assessment

An anterior segment assessment including Van Herick of the anterior chamber angle is essential when testing for glaucoma. Conditions which can cause secondary glaucoma such as pigment dispersion and exfoliative changes may be missed without viewing the anterior segment and PACG may be missed without an estimation of the anterior chamber angle.

Assessment of the optic nerve head and surrounding area

A three-dimensional view of the optic disc is optimal when assessing a 3-D structure such as the optic nerve head. Pupil dilatation is usually necessary to obtain and clear view of the optic disc. A Binocular indirect lens e.g. a Volk, or similar, lens such as a digital max field, Super 66 or 60D are optimal.

The following are considered by NICE to be strong indicators of glaucomatous damage:
Features strongly suggestive of optic nerve damage:

- Localised or generalised thinning of the neuro-retinal rim
- Notches in the neuro-retinal rim
- Optic nerve head haemorrhages without apparent secondary cause (e.g. diabetes)
- Evidence of nerve fibre layer tissue loss (not always visible)
- Vertical cup to disc ratio >0.85 (less in the presence of a small sized optic disc)

Features suggestive of possible optic nerve damage:

- Cup-to-disc (CD) ratio asymmetry between eyes of >0.2
- CD ratio > 0.6 in either eye
- Nasal cupping
- Peri-papillary atrophy
- Neuro-retinal rim thinning with possible disturbance of the 'Inferior-Superior – Nasal – Temporal' pattern (ISNT rule)
- Deep cup with prominent lamina cribrosa (soft sign)
- Bayoneting of the optic nerve head vessels (soft sign)

3.0 Management and referral criteria

Patients should be referred if the optometrist or OMP identifies one or more of the following:

1. Optic disc signs consistent with glaucoma (see above).
2. IOP >21mmHg in either eye (after repeating on 2 separate occasions with GAT/ Perkins). NB: Guidelines issued suggest that where patients are over 80 years of age and have IOPs <26mmHg with otherwise normal findings; and where patients are 65 years and over with IOPs<25mmHg with otherwise normal findings then the optometrist or OMPs may consider not referring these patients as they are at low risk of visual field loss in their lifetime. (http://www.collegeoptometrists.org/en/knowledgecentre/news/index.cfm/Glaucoma%20guideline%20guidance)
3. A visual field defect consistent with glaucoma in either eye (after repeating on 2 separate occasions).
4. A narrow anterior chamber angle on Van Herick consistent with significant risk of angle closure glaucoma in the future.
5. Conditions often associated with glaucoma (e.g. pigment dispersion syndrome or psuedoexfoliation).

Onward referrals for suspect glaucoma / OHT should record the following:

1. Description of optic disc including C/D ratio
2. Intraocular pressure (IOP), including time of day, using a GAT/ Perkins tonometer
3. Threshold related Central visual field plot from an automated perimeter capable of producing a print out (e.g. Humphrey)
4. Slit lamp assessment of anterior eye
5. Anterior chamber angle assessment (e.g. Van Herick)

Age-related Macular Degeneration

The assessment and management of AMD

1.0 Definitions

The following terms are important in this text:

1.1 Wet Age-related Macular Degeneration

Condition caused by the growth of abnormal blood vessels under the retina. Symptoms appear suddenly and progress over days or weeks. Person complains of central metamorphopsia (distortion) and / or central loss of vision. The most important signs are subretinal fluid and haemorrhage.

1.2 Dry Age-related Macular Degeneration

Condition caused by the accumulation of waste products under the retinal pigment epithelium. Symptoms develop gradually and progress over months or years. Most people are asymptomatic but may eventually complain of difficulty reading and poor vision in dim light. The most important signs are drusen, pigment epithelial atrophy and pigment clumping (so-called pigmentary changes).

2.0 Optometric assessment and management

The type of examination and frequency and composition of optometric assessment and the management protocols for different groups of patients with macular degeneration is summarised in this section.

2.1 Macular changes without visual problem

If a patient is aged over 55 years and has macular changes without visual problems they should be examined using a private or GOS sight test, followed up regularly and given appropriate advice.

1. Macular signs should be recorded diagrammatically.
2. Recall in one year for private or GOS sight test (using code 2.0 if required).
3. Inform the person about the findings and give advice about how to monitor their vision and return promptly if a change is noticed.
4. Advise the person about the benefits of a healthy diet and if they smoke explain the increased risk associated with the development of macular degeneration.

2.2 VA ≥ 6/96 with recent onset symptoms or signs

Any patient with a visual acuity of 6/96 or better in the affected eye and recent onset of central visual loss or distortion should be assessed at the earliest opportunity.

An EHEW (Band 1) examination can be carried out to differentiate between treatable and non- treatable macular degeneration with recent onset. Alternatively, if the symptoms or signs were not apparent prior to a GOS or private sight test, a Further Investigation Examination (EHEW Band 2) may be used to do further investigations to determine management.

The assessment and management should include:

1. Symptoms and History
It is important to elicit the following:
- Symptoms- duration of visual changes, description of visual changes (central loss or distortion), which eye, onset of visual changes (sudden or gradual)
- Ocular History- optometric, ophthalmological, low vision
- General Health- smoking (current, ex-smoker or non-smoker), medication e.g. chloroquine derivatives
- Family Ocular History of AMD

2. Examination (of both eyes)
Patients should have a full examination to include:
- Best corrected monocular (distance and near) visual acuity
- Refraction
- Pupil responses to light
- Fundus examination through a dilated pupil with slit lamp binocular indirect ophthalmoscopy using a volk, or similar, lens with a description of the macula noting the presence or absence of:
    - Macular drusen
    - Pigment epithelium changes (hyper/ hypo pigmentation)
    - Retinal thickening (oedema and exudates)
    - Signs of sub- retinal neovascular membrane
    - Sub-RPE or sub-retinal fluid
    - Sub-RPE, sub-retinal, intra-retinal and pre-retinal haemorrhages

3. Management:
Practitioners must determine if the patient is presenting with potentially treatable Wet Macular Degeneration, Dry Macular Degeneration, non treatable Wet Macular Degeneration or other pathology.

1. Potentially treatable Wet Macular Degeneration- refer urgently by telephone and/ or fax the same day (see referral pathways below)

2. Dry Macular Degeneration or non treatable Wet Macular Degeneration
    Information
    - Inform the patient about macular degeneration

- Inform the patient if their vision is outside the legal requirements for driving

Referral

- If both eyes are affected, refer to the Low Vision Service Wales (LVSW).
- If eligible, the person should be advised of the process and benefits of registration and offered referral for this.
- If you are concerned that a person is at risk to themselves or others, then refer urgently to social services. Otherwise referral will be initiated by the LVSW.

Advice

- Advise the person how to monitor for reduced or distorted vision and return promptly if a change is noticed
- Advise about the benefits of a healthy diet for all and the finding that nutritional supplements halt progression in some
- If the person smokes, advise them to stop smoking and provide them with details of local support networks to do this Stop Smoking Wales have a website with useful support network (http://www.wales.nhs.uk/sites3/home.cfm?orgid=754)

Recall

- Recall in one year for an EHEW (Band 1) examination.

3. Other pathology should be managed according to agreed local and national protocols and/ or guidelines.

2.3 VA ≥ 6/96 in either eye without recent onset of symptoms or signs

Any patient with a visual acuity of 6/96 or better in the affected eye who has Macular Degeneration that is untreatable is at increased risk of developing treatable Wet Macular Degeneration and so they should be monitored closely.

An EHEW (Band 1) should be carried out annually to rule out any signs of treatable disease and the management is essentially the same as that outlined in 2.2 for those diagnosed as having Dry Macular Degeneration.

2.4 Binocular VA < 6/96

According to current NHS protocols, patients in this group will not be offered treatment. Therefore, they should be monitored using the GOS system to ensure that any other ocular pathology is detected at the earliest opportunity and that they are receiving appropriate rehabilitation for their needs.

The management is essentially the same as that outlined in 2.2 for those diagnosed as having Dry Macular Degeneration. However, they should be recalled using GOS recommended intervals. Referral to the LVSW is recommended.

3.0 Referral

1. Urgent Referral of Potentially Treatable Wet Macular Degeneration - Patients with potentially treatable Macular Degeneration should be referred the same day by telephone and/ or fax (depending on the centre).
2. Routine Referral of Non Treatable Macular Degeneration - Patients who have Macular Degeneration that is not treatable who request an ophthalmological opinion should be referred to the Hospital Eye Service routinely. This should be clearly noted on the referral
3. Referral for Registration - Patients who are eligible to be registered or have their registration status changed should be referred routinely to a Consultant Ophthalmologist in the local Hospital Eye Service.
4. Referral for a Low Vision Assessment - Refer to a community based LVSW in the first instance. Contact details for services are updated regularly on the website www.eyecare.wales.nhs.uk
5. Referral to Social Services - Anyone who is at risk to themselves or others should be referred urgently to social services. Contact details for social services teams are updated regularly on the website www.eyecare.wales.nhs.uk. Routine rehabilitative support will be initiated by the low vision service.

Referral letters should include the following information:

1. Visual acuities
2. A clear indication of the reason for referral
3. A brief description of any relevant history and symptoms including onset
4. Description of the macula noting the presence or absence of:
   a Macular drusen
   b Pigment epithelium changes (hyper/ hypo pigmentation)
   c Retinal thickening (oedema and exudates)
   d Signs of sub- retinal neovascular membrane
   e Sub-RPE or sub-retinal fluid
   f Sub-RPE, sub-retinal, intra-retinal and pre-retinal haemorrhages

Retinal Breaks and Detachments

The assessment and management of patients with real or suspected retinal breaks or detachment.

1.0 Definitions

1.1 Retinal break

This is a retinal tear, hole or operculum.

1.2 Retinal detachment

This is any type of retinal detachment including rhegmatogenous, tractional or exudative.

2.0 Assessment

2.1 History and symptoms

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

1. History
    - Age (patients over 50 years of age are more likely to develop breaks)
    - Myopia (over -3D)
    - Family history of retinal break or detachment
    - Previous ocular history of break or detachment
    - Systemic disease (e.g. Diabetes, Marfans syndrome)
    - History of recent ocular trauma, surgery or inflammation
2. Symptoms
    - Loss or distortion of vision (a curtain / shadow / cloak/ veil)
    - Floaters
    - Flashes

For symptoms of floaters these additional questions should be asked:
- Are floaters of recent onset?
- What do they look like?
- How many are there?
- Which eye do you see them in?
- Any flashes present?

For symptoms of flashes these additional questions should be asked:
- Describe the flashes?

- How long do they last?
- When do you notice them?

For symptoms of a cloud, curtain or veil over the vision these additional questions should be asked:

- Where in the visual field is the disturbance?
- Is it static or mobile?
- Which eye?
- Does it appear to be getting worse?

Symptoms of less concern:

- Long term floaters and/ or flashes of >2 months duration

2.2 Examination

All patients presenting for an EHEW with symptoms indicative of a potential retinal detachment should have the following investigations (in addition to such other examinations that the optometrist or OMP feels are necessary):

1. Tests of pupillary light reaction, including swinging light test for Relative Afferent Pupil Defect (RAPD), prior to pupil dilatation
2. Visual acuity recorded and compared to previous measures
3. Contact tonometry noting any IOP discrepancy between eyes (IOP lower in affected eye) with a Goldmann/ Perkins
4. Slit lamp biomicroscopy of the anterior and posterior segments, noting:
   a Pigment cells in anterior vitreous, 'tobacco dust' (Shafer's sign), particularly in the absence of any recent intraocular surgery
   b Vitreous haemorrhage
   c Cells in anterior chamber (mild anterior uveitic response)
5. Dilated pupil fundus examination with slit lamp binocular indirect ophthalmoscopy using a Volk, or similar lens (Digital wide field, Superfield, Super Vitreo fundus lens optimal) asking the patient to look in the 8 cardinal positions of gaze and paying particular attention to the superior temporal quadrant (as 60% of breaks occur here) noting:
   a Status of peripheral retina, including presence of retinal tears, holes, detachments, operculums or lattice degeneration
   b Presence of vitreous syneresis or Posterior Vitreous Detachment (PVD)
   c Is the macula on or off (i.e. does the detachment involve the macula or not)
6. Visual field examination at discretion of optometrist or OMP

3.0 Management and referral criteria

Local hospital arrangements may vary for dealing with retinal problems. It is useful to be aware of the local arrangements as this may affect the management of patients. A telephone call may be required to establish to which hospital to send the patient.

3.1 Symptoms requiring urgent review within 24 hours

- Sudden increase in number of floaters, patient may report as "numerous", "too many to count" or “sudden shower or cloud of floaters” - Suggests blood cells, pigment cells, or pigment granules (from the retinal pigment epithelium) are present in the vitreous. NB Should be signs of retinal break or detachment present
- Cloud, curtain or veil over the vision - Suggests retinal detachment or vitreous haemorrhage – signs of retinal break or detachment should be present

3.2 Signs requiring referral within 24 hours

- Retinal detachment with good vision – Macula on
- Vitreous or pre-retinal haemorrhage
- Pigment ‘tobacco dust’ in anterior vitreous
- Retinal tear/ hole with symptoms

3.3 Signs requiring referral to next available clinic appointment at the HES

- Retinal detachment with poor vision - Macula off
- Retinal hole/ tear without symptoms
- Lattice degeneration with symptoms of recent flashes and/ or floaters

3.4 Signs requiring discharge with advice about what to do if patients have symptoms of a retinal detachment (patients to be given verbal advice and a leaflet of written advice*).

- Uncomplicated PVD or partial PVD without signs and symptoms listed in 3.1, 3.2 or 3.3
- Signs of lattice degeneration without symptoms listed in 3.1, 3.2 or 3.3

4.0 Referral letters

Patients requiring referral for retinal breaks or detachment must have the following noted in the referral letter to the ophthalmologist. Letters should be typed whenever possible and may be faxed or sent with the patient in urgent cases.

- A clear indication of reason for referral as a title to referral, e.g retinal tear in superior temporal periphery of right eye
- A brief description of any relevant history / symptoms
- A drawing or description of the location of any retinal break / detachment / area of lattice with disc and macula for scale
- Urgency of the referral
- Whether the macula is on or off (i.e. is the macula region detached or not) – this has a bearing on the urgency of the referral; see 3.2 and 3.3 above

5.0 Record keeping

- Optometrist or OMPs are reminded to keep full and accurate records of all patient encounters. This includes when the patient is spoken to on the telephone (by the optometrist or OMP or another member of staff) as well as when they are in the consulting room.
- All advice that is given to the patient should be carefully noted, together with any information that was given to the patient.
- *Patient leaflets about flashes and floater symptoms are available from the College of Optometrists website in the members area http://www.college-optometrists.org/en/knowledge-centre/publication/patient-leaflets/download.cfm
  or from the Association of Optometrists' (AOP) website http://www.aop.org.uk/search?q=retinal+detachment
- Negative as well as positive findings should be noted (e.g. 'no retinal tears or breaks seen').

Cataract

The assessment and management of patients with cataract.

1.0 Assessment and management of patients with cataract

This assessment may be conducted as a Further Investigation Examination (EHEW Band 2) following a GOS or private sight test.

1.1 History and symptoms

It is important to elicit the following:

- Type of vision deterioration, does it affect distance vision, near vision or both
- Length of time of vision deterioration (should not be sudden onset)
- If everyday tasks are affected by the vision deterioration, particularly related to driving

1.2 Examination

Patients found to have significant cataracts should have the following investigations prior to referral to the HES (in addition to other such examinations that the optometrist or OMP feels are necessary):

- Visual acuity - Recorded and compared to previous recordings where available
- Pinhole VA
- Contact tonometry - Using Goldmann or Perkins
- Slit lamp biomicroscopy of the anterior and posterior segments through a dilated pupil noting location and type of cataract
- Fundus examination through a dilated pupil with slit lamp binocular indirect ophthalmoscopy using a Volk, or similar lens (60D ,Super 66 or digital high mag optimal) with careful assessment of macula status (if AMD present then AMD protocol to be followed)

1.3 Management and referral criteria

If a cataract is found then this should be discussed with the patient. If the cataract is not causing any significant vision or lifestyle problems then the patient can be monitored appropriately. If the patient wishes to consider surgery then they should be given a questionnaire to complete and an information leaflet about cataract operation. On completion of the questionnaire the optometrist or OMP must take the time to explain to patients about the benefits and risk of the operation and discuss any points raised by the patient about the questionnaire; this can be done on another

visit if necessary. Patients may need time to digest the information before they indicate a willingness to go ahead with the referral.

Referral Letter

Patients requiring referral for cataract must have the following noted in the referral letter to the ophthalmologist:

- A clear indication of reason for referral as a title for the referral
- That the patient is willing to consider surgery
- Visual Acuity now and what it was previously (including date of previous VA)
- Pinhole VA, if appropriate
- Confirmation that the cataract is main cause of sight loss
- Notification of any co-existing ocular pathology
- Confirmation that the patient's lifestyle and/ or quality of life is compromised as a result of the cataract
- The referred eye for surgery
- Previous history of cataract surgery or refractive surgery
- A list of any medications taken by the patient
- A copy of the questionnaire should be sent with the referral.
- The presence or absence of AMD

GLOSSARY OF TERMS

Clinical audit
Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary.

Clinic lead
A designated person responsible for the development of a clinical service, ensuring the quality of care is good and best practice is maintained and upheld.

Eye Health Examination Wales (EHEW)
EHEW is a replacement for both PEARS and WEHEW services. It enable patients with sudden onset eye problems and those in at-risk categories for developing eye disease or those who would find losing their sight particularly difficult to obtain a free eye examination from an accredited optometrist in the community.

General Ophthalmic Services (GOS)
The provision of sight tests when clinically necessary to eligible patients by optometrists or ophthalmic medical practitioners including providing optical vouchers to eligible patients to assist them in the purchase of glasses or contact lenses.

NHS Wales (GIG Cymru)
NHS Wales:Gwasanaeth Iechyd Gwladol Cymru is the publicly funded healthcare system of Wales and is the responsibility of the Welsh Government. It provides emergency services and a range of primary care, secondary care and specialist tertiary care services

NHS Wales Shared Services Partnership (SSP)
The NHS Wales Shared Services Partnership is a dedicated Shared Services organisation which shares common operating standards in line with best practice, has sufficient scale to optimise economies of scale and purchasing power and has an excellent customer care ethos and focus on service quality. They support the statutory Health Boards and NHS Trusts in Wales and provide professional advice and support to Welsh Government.

Optometry Wales
Optometry Wales is the professional umbrella organisation for all community optometrists, opticians and dispensing opticians in Wales. It represents the profession in lobbying and negotiation with Welsh Government, responding to consultations and ensuring the profession is represented at all levels in Wales

Post-payment Verification (PPV)
A process of financial audit of NHS claims. PPV is carried out by the Shared Services Partnership (SSP) in-line with an agreed protocol. The SSP is entitled to inspect records relating to NHS patients, including mixed NHS and private records relating to a patient.

Primary Eyecare Acute Referral Service (PEARS)
An eye examination for patients with an eye problem requiring urgent attention that was available from the community optometrist free of charge to the patient. This service was available from 2003-2012 but has been superseded by the EHEW.

Wales Eye Care Service (WECS)
A new eyecare service, introduced in 2012, that is structured so that patients can be managed appropriately and effectively by optometrists in the community. The three banding structure includes Eye Health Examination Wales (EHEW), further investigation/ examinations and a follow-up service. The service is free to patients in Wales who are eligible under one of the categories for a WECS and visit an accredited optometrist.

Wales Optometry Postgraduate Education Centre (WOPEC)
WOPEC is the first postgraduate education centre for optometry in the world and is dedicated to excellence in eye care education through quality and independence. WOPEC provides short courses for optometrists and eye care professionals as well as certified postgraduate courses and helps to facilitate training and accreditation for the WECS. It is located in the School of Optometry in Cardiff University.

Welsh Eye Health Examination Wales (WEHEW)
The aim of the WEHEW is to detect those patients at increased risk of eye disease and those patients who would find losing their sight particularly difficult. Patients in Wales were entitled to a free at the point of access WEHEW eye examination from an accredited optometrist if they fulfilled specific criteria. This service was available from 2003-2012 but has been superseded by the EHEW.

Welsh Government (WG)/ Llywodraeth Cymru
The Welsh Government is the devolved Government for Wales. It has legislative powers in key areas of public life such as health, education and the environment.

Welsh Optometric Committee (WOC)
The Welsh Optometric Committee (WOC) is the Statutory Advisory Committee to the Welsh Government (WG), advising on all aspects of optometry and optometrists issues in Wales. It consists of Members from Regional Optometric Committees, Cardiff University School of Optometry and the Hospital Eye Service in Wales. It has observers from WG, WOPEC, and a reciprocal observer from the Ophthalmology Specialist Advisory Group (OSAG: part of Welsh Medical Committee). It occasionally commissions sub-groups for the purposes of developing particular areas of influence.