Agenda – Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 5 Tŷ Hywel
a fideo gynadledda drwy Zoom
Dyddiad: 20 Mawrth 2025
Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:
Sarah Beasley
Clerc y Pwyllgor
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SeneddIechyd@senedd.cymru

Yn ei gyfarfod ar 5 Mawrth, cytunodd y Pwyllgor ar gynnig o dan Reol Sefydlog 17.42 (ix) i wahardd y cyhoedd o eitemau 1 o'r cyfarfod heddiw.

Rhag-gyfarfod preifat

(09.00-09.30)

1 Adroddiad monitro amseroedd aros y GIG

(9.00-9.30) (Tudalennau 1 - 24)

Papur 1 – Adroddiad monitro amseroedd aros y GIG

Cyfarfod cyhoeddus

(9.30-14.40)

2 Cyflwyniadau, ymddiheuriadau, dirprwyon a datgan buddiannau

(09.30)

3 Gwasanaethau Offthalmoleg yng Nghymru: sesiynau tystiolaeth - Panel 1

(9.30-10.30) (Tudalennau 25 - 54)

Rhianon Reynolds, Arweinydd Clinigol Cenedlaethol ar gyfer Offthalmoleg, Rhwydwaith Gweithredu Clinigol – Gweithrediaeth y GIG
Offthalmolegydd Ymgynghorol a Chyfarwyddwr Clinigol, Bwrdd Iechyd Prifysgol Aneurin Bevan
Llywydd Coleg Brenhinol yr Offthalmolegwyr yng Nghymru

William Oliver, Rhwydwaith Gweithredu Clinigol Offthalmoleg ar gyfer Gofal wedi'i Gynllunio – Gweithrediaeth GIG Cymru

Briff Ymchwil
Y Strategaeth Glinigol Genedlaethol ar gyfer Offthalmoleg
Papur 1 – Coleg Brenhinol yr Offthalmolegwyr – Ymateb i'r ymgynghoriad

Egwyl

(10.30–10.45)

4 Gwasanaethau Offthalmoleg yng Nghymru: sesiynau tystiolaeth – Panel 2

(10.45–11.45) (Tudalennau 55 – 57)

Dr Andrew Pyott – Offthalmolegydd Ymgynghorol, Arweinydd Clinigol – Offthalmoleg – GIG Ucheldir yr Alban

Papur 2 – Papur briffio: Dr Andrew Pyott, Offthalmolegydd Ymgynghorol ac Arweinydd Clinigol mewn Offthalmoleg

Cinio

(11.45–12.30)

5 Gwasanaethau Offthalmoleg yng Nghymru: sesiynau tystiolaeth – Panel 3

(12.30–13.30) (Tudalennau 58 – 61)

Owain Mealing, Cadeirydd – Optometreg Cymru
Dan McGhee, Cyfarwyddwr anweithredol – Ffederasiwn yr Optometryddion ac Optegwyr Cyflenwi
Dr Peter Hampson, Cyfarwyddwr Clinigol a Pholisi – Cymdeithas yr Optometryddion

Papur 3 – Optometreg Cymru: ymateb i'r ymgynghoriad

Egwyl

(13.30-13.40)

6 Gwasanaethau Offthalmoleg yng Nghymru: sesiynau tystiolaeth - Panel 4

(13.40-14.40) (Tudalennau 62 - 69)

Owen Williams, Cyfarwyddwr - Cyngor Cymru i'r Deillion

Ansley Workman, RNIB Cymru

Marian Williams, Cymdeithas Facwlaidd

Lowri Bartrum, Vision Support

Papur 4 - RNIB Cymru: ymateb i'r ymgynghoriad

7 Papurau i'w nodi

(14.40)

7.1 Llythyr at y Gweinidog Iechyd Meddwl a Llesiant yn dilyn sesiwn graffu'r Pwyllgor ar gyllideb ddrafft Llywodraeth Cymru

(Tudalennau 70 - 71)

7.2 Llythyr oddi wrth y Gweinidog Iechyd Meddwl a Llesiant mewn ymateb i gwestiynau dilynol o sesiwn graffu'r Pwyllgor ar gyllideb ddrafft Llywodraeth Cymru

(Tudalennau 72 - 74)

7.3 Llythyr oddi wrth Gadeirydd y Pwyllgor Deisebau ynghylch Deiseb P-06-1488: Sefydlu 'Cymdeithas Gofal' i Fynd i'r Afael â'r Argyfwng COVID Hir yng Nghymru

(Tudalennau 75 - 76)

8 Cynnig o dan Reol Sefydlog Rhif 17.42(ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

(14.40)

Cyfarfod preifat

(14.40-15.00)

9 Gwasanaethau Offthalmoleg yng Nghymru: ystyried y dystiolaeth

(14.40–15.00)

Mae cyfyngiadau ar y ddogfen hon

Mae cyfyngiadau ar y ddogfen hon

Inquiry into Ophthalmology services in Wales

March 2025

Half of the highest risk eye patients (those at risk of irreversible harm if they miss their target date for an outpatient appointment) on ophthalmology waiting lists in Wales have already waited at least 25% beyond their target date.

This is very concerning, given for patients with conditions such as glaucoma and age-related macular degeneration these long waits are likely to lead to irreversible sight loss. Demand is set to grow further in the coming years. Our cross sector Eye Care Data Hub shows that in Wales the prevalence of primary open-angle glaucoma is projected to increase by 16% over the next decade, while there will be a 23% jump in the prevalence of neovascular age-related macular degeneration.

Clearly urgent action is needed to address this situation. The National Clinical Strategy for Ophthalmology, commissioned by the Welsh Government and NHS Wales and published in September 2024, provides a comprehensive analysis of the challenges facing ophthalmology services. Most importantly, it lays out what needs to happen next to put integrated eye care services on a sustainable footing. The Royal College of Ophthalmologists fully endorses the conclusions of the Strategy, and the need to adequately resource the Ophthalmology Clinical Implementation Network in the coming months and years to deliver it.

Our response to this inquiry highlights the three key enablers to improving eye care services in Wales – digital transformation, improving estates to facilitate regionalised care, and putting in place the workforce to meet demand.

1. Digital transformation

A 2024 Royal College of Ophthalmologists survey of clinical leads found that no ophthalmology department in Wales had a well-functioning electronic patient record (EPR) system, interoperable patient records with optometry, nor an electronic eye care referral system.

These are all serious blockers to the delivery of more efficient integrated services, and the delivery of care closer to people's homes as envisaged by WGOS reforms.

The roll out of an ophthalmology specific national EPR system, accessible in both primary eye care services and hospital eye services, is essential and long overdue. This will need investment and leadership from the Welsh Government to facilitate Digital Health and Care Wales and health boards implementing the ophthalmology EPR at pace.

Likewise, an electronic referral system between primary and secondary eye care is needed to deliver more efficient care and bring down waiting lists. Both of these solutions were identified as long ago as a 2016 review undertaken by Healthcare Inspectorate Wales, but frustratingly little progress has been made since then.

2. Improved estates to facilitate regionalised care

The capacity of ophthalmology estates to properly meet demand is a UK-wide problem. In our 2024 survey of ophthalmology clinical leads, sufficient clinic space was the joint most cited factor that would improve patient services.

We know however that Wales has particularly severe challenges with both the capacity and condition of its estates. One unit has highlighted a lack of ultrasound or pan-retinal photocoagulation laser and microscopes operating at the end of life.

The National Clinical Strategy for Ophthalmology (NCSOphth) also found that '*CAVUHB have regular problems with leaks from toilets above into clinical areas, and ABUHB had to stop all activity in 2023 when there was a roof collapse due to a faulty overflow pipe. BCUHB ophthalmology has ivy growing through walls and a roof that requires buckets when it rains. Patched floors create an unsafe environment for those with visual impairment to navigate, creating accessibility issues for the people most in need of our help'.*

The NCSOphth rightly advocates that this needs a fundamental rethink of how care is delivered in Wales, with complex care undertaken at central sites with more routine care in local hospital eye services supported by primary and community eye care services. This will require investment in all sites, with central hubs 'large enough to accommodate need, at the forefront of technology and advanced clinical care with enough space to train medical and nonmedical colleagues and to allow predicted expansion of demand'.

3. The workforce in place to meet demand

Addressing the challenges faced by NHS estates can also facilitate another key enabler for improving services – having sufficient workforce in place to meet rising demand.

In recent years enhanced optometry services have developed which mean more care can be delivered in this setting which would previously have been referred into hospital eye services. This is a positive shift, embedded in the new 2023 optometry contract. This will will mean patients at the lowest risk of vision loss, that still need ongoing care, receive care closer to home.

Unfortunately those at much higher risk of sight loss and requiring more complex care will need treatment in the hospital eye service, overseen by consultant ophthalmologists.

Wales has much lower number numbers of consultant ophthalmologists per population head than most of the rest of the UK. Wales has 1.97 ophthalmologists per 100,000 population, far below our minimum recommended ratio of 3 to 100,000 to deliver effective hospital eye services. Many sites, particularly in West Wales, face significant recruitment and retention issues. This is leading to an increasing reliance on locums to fill gaps.

As a move towards sustainably filling these shortages, we recommend a phased approach to increasing ophthalmology specialty training places – with an additional 36 places by 2031.

We also recommend that the Welsh Government adopts a granular approach to workforce planning, taking into account prevalence data for all eye conditions and the optimum workforce team needed to manage care. The Royal College of Ophthalmologists has begun to undertake this work for each sub-specialty through expert working groups, captured on an ongoing basis in this online resource. This shows, for example, that for glaucoma care we need at least 0.6 glaucoma teams (1 consultant, 2 resident doctors, 1 optometrist, 1 nurse) per 100,000 population head. This would require a minimum of 19 glaucoma teams in Wales.

The Royal College of Ophthalmologists looks forward to working with policymakers in Wales to ensure we have the right workforce in place to meet demand for eye care services, alongside tackling the other key challenges identified in this response.

Eitem 4

Senedd Hearing 20th March 2025
Briefing Notes

In September 2021 a document entitled "External Review of Eye Care Services in Wales" was published and this would be a useful starting point for any discussion. In particular, the ten recommendations made then, would merit investigation as to what extent they have been fulfilled.

Scotland is a country of similar size and faces some of the geographical and other challenges experienced in Wales.

It may be useful to discuss areas where another devolved Health Department (with similar funding arrangements) have been able to make changes.

There are some aspects which might merit comparisons between the two nations.

1/ OpenEyes

There is now a planned roll out of this electronic system throughout the country. Greater Glasgow and Clyde have been the first Health Board to fully adopt this EPR (electronic patient record), and they now have no paper notes.

2/ NESGAT (NHS Education for Scotland Glaucoma Award Training)

As mentioned in the report, Scotland has a higher number of Independent Prescribing Optometrists than other parts of the UK. Those with specific training in the management of Glaucoma can now manage patients whom the Hospital Eye Service (HES) deem stable. These patients are discharged from HES until such time as a re-referral is deemed necessary. This scheme is being rolled under around the country.

3/ Cataract services.

It was previously reported the average number of cataract surgeries performed in a 3.5 hour session in Scotland was 5.6. There is impetus for each unit in the country to

regard that one cataract operation every 30 mins (cataract only lists) is the absolute minimum. This should be irrespective of training or "service only". More units are now using Immediate Sequential Bilateral Cataract Surgery (ISBCS) as a means of encouraging theatre efficiency, with residents being exposed to the technique.

There is also the development of High-volume cataract surgery training being proposed for residents. Currently, the only venue is the Golden Jubilee National Hospital, Clydebank. In a six-month period, a senior resident might expect to perform 300 to 400 surgeries and a junior 100-150. It is proposed to make this experience available to more surgeons in training at other sites around the country.

The harsh fiscal environment has led to the cancellation of several of the planned Elective Care Centres, but the National Treatment Centre Highland (NTCH) was opened in March 2023 and now accepts patients from other parts of the country. This is proving an effective way of tackling very long waits for treatment. The NTCH has met the minimum requirement of 7 on a (cataract only) list for all surgeons, and several surgeons regularly achieve more than this.

Throughout the country there is patchy engagement with improving theatre efficiency. It is not always straight-forward to identify the impediments, but frequently there can be perverse disincentives for the nursing staff, especially when they do not work in dedicated ophthalmic teams.

Scotland does not yet have the serious competition brought about by using the Independent Sector to bring down waiting times that has been experienced in England. (Over 50% NHS Cataract surgery in England performed by Independent Providers). However, quite a number of Health Boards have been inviting the independent sector to use theatres at weekends, often with contracts that insist on higher numbers than are the norm for standard NHS lists during the week.

Like some units in Wales, there are some departments where theatre efficiency is compromised by Intra-vitreal injections (IVT) being performed in theatre rather than a clean room in the Out-patient department (OPD).

4/ Other long-term conditions

It is always dangerous to equate Ophthalmology with "Cataract surgery". There are justifiable concerns about the long waits for what should be a quick and reliable procedure to reverse sight loss. However, even more urgent are those return patients with long term conditions for whom treatment is more time limited. If a Macula service is not able to treat patients in a timely manner, then not only might the individual be exposed to the risk of irreversible sight loss, but the Health Board may have been wasting expensive treatments for poor gain. Some treatments require to be given at the correct dosing interval or not at all.

The Economics of the use of biosimilars or novel treatments with extended dosing intervals may need to be discussed.

5/ Estate

At the time of the 2021 Report significant concerns were raised regarding the Estate across many of the Welsh Health Boards.

6/ Vitreo-retinal (VR) services.

The 2021 Report also raised concerns regarding cross-border patient flows and a lack of long-term resilience in the Welsh VR provision.

Andrew Pyott

12/03/2025

Eitem 5

Optometry Wales
Optometreg Cymru

Optometry Wales Written Response to the Health & Social Care Committee's short inquiry into Ophthalmology Services in Wales.

Optometry Wales is the umbrella professional body for all community optometrists, dispensing opticians and optometric practices in Wales with our main function to represent the profession at all levels in Wales. Optometry Wales negotiates on behalf of the statutory bodies (the Regional Optical Committees) with Welsh Government and NHS Wales in respect of national NHS services provided by optometry in primary care.

Optometry Wales is pleased to be invited to both attend to provide oral representation and a written response to the Health and Social Care Committee inquiry into Ophthalmology.

1. Organisational reform and service efficiency

In October 2023, Welsh Government advanced the integration of primary and community care optometrists through Optometry Contract Reform under Wales General Ophthalmic Services (WGOS) consisting of five levels of service. Initial integration of services which led to the shift of services from secondary care to optometry commenced in 2003 with PEARS (Primary Eyecare Assessment and Referral service), 2004 with Low Vision Service Wales and in 2013 with the Eye Health Examination Wales Service. Welsh Government (WG) policy documents[1,2,3,4] have supported this shift of services from secondary care to primary care optometry. The policy direction of WG to support health board optometric advisers and health board hosted Eye Care Collaborative Groups has ensured that the shift of services can be supported via a shared collaboration between optometry and ophthalmology. The aim of the integrated eye care pathways is to reduce the number of referrals into hospital eye departments by 1/3 (referral filtering), and to increase capacity in hospital departments by freeing up 35,000 follow up appointments through monitoring, management and treatment in primary care. Optometry practices across Wales have fully embraced the change and the move to a more clinical focus with many clinicians undertaking additional training to upskill in the required qualifications.

The new Independent Prescribing Service (WGOS5) has had time to embed across Wales with significant patient numbers (over 2000/ month across 90+ practices, with the highest number of service delivery being seen in February claim data of nearly 3000 patients supported) being seen in primary care that would traditionally have been seen in Eye Casualty hospital clinics and with more optometrists qualifying as independent prescribers in Wales on a monthly basis this is expected to continue.

WGOS4 (Glaucoma, Medical Retina and Hydroxychloroquine) services are in the process of being rolled out across Wales and are not yet fully embedded. The Health Boards that previously had local services prior to contract reform which have transitioned to the new

services have been faster to implement the new services, but all 7 Health Boards have now commenced at least one of the patient pathways. However, patient numbers are starting to increase with a doubling of service delivery seen in the February 2025 claim data in comparison to January 2025 (800 WGOS4 services provided in comparison to 419). 73 practices across Wales are now listed to deliver these services with more practices due to join WGOS4 once all health boards have established all elements of the service and further optometrists are undergoing training across Wales to also undertake the services.

2. ***Workforce expansion and training**:*

As part of 2023 Optometry Contract Reform, WG has introduced a Quality For Optometry mandatory contract requirement for all optometry practices. From January 2025, this requires all optometry practices to submit monthly workforce data which includes their skillset and higher qualifications. This data will be crucial to identify any workforce shortages to then support targeted interventions whether for increasing in a particular qualification or in a specific geographic area.

During the recent contract negotiations Optometry Wales proposed the establishment of an optometry workforce group which was agreed to be taken forward although has not yet commenced. Optometry Wales would like to see that workforce group taking a holistic approach to the review of workforce for both optometrists and dispensing opticians from the point of entry to training (and recruitment) including at undergraduate level through to higher qualifications in Independent Prescribing, Glaucoma, Medical Retina and Low Vision, with a need to map the (current and future) demand for primary care optometry services against current workforce and against all areas of Wales.

Welsh Government have supported the upskilling of optometrists and dispensing opticians via funding provided to Health Education and Improvement Wales to obtain higher qualifications in Independent Prescribing, Glaucoma, Medical Retina and Low Vision. Optometry practices, clusters and health boards have also provided funding for these higher qualifications.

Welsh Government have supported the establishment of three teach and Treat Centres in North, West and South Wales. This ensures that clinical placements required for many of the higher qualifications can be accessed by all practitioners in a timely manner, delays have however meant that North Wales Teach and Treat clinic only came on line in the latter part of 2024. In addition, WG have supported HEIW to establish Advanced Training Practices which fund appropriately skilled optometrists to host a clinical placement within their own practice to further enhance placement capacity. WG are funding practices who release practitioners to complete glaucoma clinical placements for time taken out of practice. WG is the only UK government to support optometrists and dispensing opticians with a tiered level of remuneration for continuing professional development grants based on their use of higher qualifications within WGOS.

3. ***Hospital and infrastructure improvements**:*

Optometry Wales Board is frustrated with the delays of implementation of the ophthalmic electronic patient record (EPR) and eye care referral system (ERS). The lack of a shared care ophthalmic EPR and digital eye care referral solution is adding an administrative burden to both optometry and ophthalmology as onerous administration is required to accommodate referrals from optometry to ophthalmology and to discharge secondary care patients from ophthalmology to optometry. This administrative burden means that there is double keying of data for optometry practitioners which reduces clinical capacity to see more patients and support with the reduction of ophthalmology waiting lists. Optometry Wales has been working with WG, DHCW and NHS Wales to support in whatever means possible to overcome the challenges involved with delivery of an ophthalmic EPR and electronic referral solution.

4. ***Clinical Networks and equal access to care**:*

Optometry Wales is a member of the Ophthalmology Clinical Implementation Network (CIN) which brings together all stakeholders including third-sector organisations to discuss and agree ways to ensure equal care across regions, addressing disparities in care delivery and waiting time performance. In each of the Health Boards Eye Care Collaborative Groups (ECCGs) have been established with both primary and secondary care inclusion to ensure sharing of information, frequency of ECCG meeting is variable across the Health Boards.

Health Boards also report progress of Optometry contract reform implementation via a national reporting template and share best practice with all groups. This common sharing of WGOS data alongside ophthalmology waiting time data supports the assessment of new optometry care pathways alongside the data that is collated from the payment/audit WGOS claim forms. Data relating to the number of patients seen under WGOS alongside the number of patients discharged from ophthalmology to WGOS supports the assessment of the effectiveness of new care pathways. NHS Wales Shared Services Partnership has committed to the introduction of a national dashboard to share this data with key stakeholders.

5. ***Oversight and implementation**:*

Optometry Wales Board is frustrated with the delays of implementation of digital strategies within eyecare with a significant amount of clinician time being taken up by administrative workload. Lack of digital solutions is hindering health boards in discharging patients to optometry as a paper exercise is required rather than optometry being able to access a patient digital record. Optometry Wales awaits a further update from DHCW on next steps to progress the digital solutions that are essential to support the transformation in eye care, reduce ophthalmology waiting lists and thus reduce the risk of irreversible sight loss.

References

1. Together for Health:Eye health care delivery plan(2013-2018) Annual report 2014 english
2. Well-being of Future Generations (Wales) Act 2015: the essentials [HTML] | GOV.WALES
3. A healthier Wales: long term plan for health and social care | GOV.WALES
4. NHS Wales eye health care: future approach for optometry services | GOV.WALES

Eitem 6

RNIB Cymru
Golwg gwahanol
See differently

RNIB Cymru briefing for Senedd Cymru Health and Social Care Committee Ophthalmology Inquiry

Contact: [redacted]

Eye Watering: ophthalmology waiting lists in Wales

More than **80,000 patients** at the **greatest risk of permanent sight loss** are waiting too long for sight saving treatments – more than enough to fill the Principality Stadium to capacity.

The number of ophthalmology patients waiting beyond their target date has **more than doubled** in the past five years. The former President of the Royal College of Ophthalmologists in Wales has warned of a “tidal wave of blindness across the whole country”, the consequences of which would be “catastrophic” if services are not reformed.

Sadly, for many who do lose some or all their sight, this could have been avoided if they were seen on time. We hear from grandparents who’ve lost so much sight while on a waiting list that they never saw the faces of their newborn grandchildren. People waiting for treatment have lost their jobs, which depended on them being able to drive, which they could no longer safely do. What makes this truly heartbreaking is the knowledge that things could have been so different if only they had received the right care and treatment at the right time.

Rising demand for eye care services

Half of all sight loss is avoidable with early detection and treatment. But the prevalence of eye diseases like glaucoma and age-related macular degeneration increases as our population grows older. One in five people will live with permanent sight loss in their lifetime and demand for eye care services is expected to rise by as much as 40 per cent over the next 20 years.

Ophthalmology services in Wales are already under immense pressure. Ophthalmology is the busiest outpatient specialism in the Welsh NHS, accounting for one in every seven patients on the waiting list.

The number of patients waiting for an ophthalmology appointment increased by 169 percent in the past decade. Wales has the lowest numbers of Consultant Ophthalmologists per capita of any of the UK nations and in Europe only North Macedonia has fewer.

The National Clinical Strategy for Ophthalmology

In September 2024, the NHS Wales Executive published its clinically-led blueprint for reforming ophthalmology services across Wales, the National Clinical Strategy for Ophthalmology.

Among the strategy's key recommendations is a fundamental redesign of the delivery model of eye care centered around three purpose-built regional centres of excellence which would enable services to attract and retain qualified staff, and allow for ophthalmic capacity, expertise, and technologies to be pooled to ensure an efficient and sustainable service. The Royal College of Ophthalmologists in Wales described the move to a regional model as 'vital for survival of ophthalmic care in Wales'. In the short term, the strategy calls on health boards to align governance finance and priorities to a regional delivery model agree a regional ophthalmology budget which is ringfenced and pooled with a central finance governance not dependent on individual Health Board constraints.

The Cabinet Secretary published a written statement in December outlining his support for the strategy and his expectations for progress to be made towards its implementation. Whilst this is a positive step, there have been no deadlines put in place and no additional funding allocation to deliver the reforms. It remains unclear who is responsible for coordinating and monitoring the shift to a regional delivery model and whether health boards have dedicated resources responsible for taking this forward.

Delays to digitisation

An electronic patient record and referral system (EPR) which intended to give hospital ophthalmologists and community optometrists access to shared clinical information to monitor eye health and provide shared care was launched in 2021. Four years later, the system is still not operational in any health boards in Wales and does not fulfill most of the core functions it was intended to.

The National Clinical Strategy for Ophthalmology notes the “considerable frustration around the lack of EPR and referral systems” and urges Welsh Government to prioritise and fast track the implementation of an EPR via Digital Health and Care Wales with the sufficient resources, clinical leadership, functionality and data interconnectivity across Wales to support the ambitions of this strategy and to ensure seamless movement of patients and clinical information between community and hospital services. In addition, a complete digital strategy for eye care needs to be developed to ensure services are optimised.

To date, there has been no public ministerial commitment to commission the digital strategy and there is no roadmap in place for the implementation of EPR.

Key points for the inquiry to consider

It has been four years since an External Review of Eye Care Services in Wales described the staffing situation facing Wales' eye care services as "extremely serious" and "very fragile".

The National Clinical Strategy provides the blueprint for a modern eye care system that is capable of meeting rising demand and able to deliver care to patients at the right place and at the right time. The ophthalmology clinical sector has warned that "inaction risks the collapse of eyecare services in Wales" and described the National Clinical Strategy as "the last chance we have to plan a viable future for eyecare in Wales."

To date, there has been no commitment from the Welsh Government to make significant investments needed to implement the recommendations of the National Clinical Strategy. Without this, Wales' eye care waiting lists will continue to rise as will the number of patients who are needlessly losing their sight while waiting for NHS treatment.

The Welsh Government must commit the necessary resources to facilitate the shift to a sustainable regional delivery model. Health boards will not be likely to commit to a fundamental reorganisation of services without appropriate incentives, resources and ministerial direction. Currently, there is no incentive for a well performing health board to pool resources with an under-resourced or poorly performing health boards nearby. This hinders the shift to a regional model of delivery which the entire eye care sector in Wales agrees is the only viable future for the service. The Welsh Government must set clear expectations, including milestones and targets for implementation of the National Clinical Strategy. It must also equip the NHS Executive with the resources and powers it needs to drive operational change before we will begin to see progress towards a regional delivery model.

In addition, there is a considerable disparity between the number of people waiting beyond their target date and the number that are reported as

having suffered harm as a result. In the absence of Standard Operating Procedures that would apply in the event of an unexpected death in other clinical specialties as a result of a treatment delay, ophthalmology relies on the reporting of patient safety incidents through the DATIX system.

RNIB Cymru's 2023 Freedom of Information Request to Public Health Wales (FOI 2023 147) revealed that between June 2021, when 64,790 patient pathways were beyond their target date, and September 2023, when the figure was 77,230 patient pathways, only 45 patient safety incidents were reported across Wales relating to ophthalmic services.

This is almost certainly a significant underreporting of the scale of harm befalling patients and clearly shows that the system is not working. It is critically important that services accurately quantify the numbers of patients who have lost sight as a consequence of delayed treatment.

If incidents of harm are not reported then they are not investigated, remedial action is not taken, improvements are not identified, and learning is not embedded to prevent similar incidents occurring in the future. Equally, decision makers, including Health Board leaders, the NHS Executive, the Cabinet Secretary for Health and Social Services and the Senedd Health and Social Care Committee have no insight into the scale of real harm that is being experienced by eye care patients and are therefore unable to make fully informed decisions about where to focus resource and attention to improve patient safety.

The Welsh Government must improve the accurate reporting of the harm caused by delays to diagnosis and treatment so that eye care is afforded appropriate priority alongside other long-term chronic conditions.

While we wait and hope for a commitment and investment from the Welsh Government to support these plans to improve our eye care services, more than 80,000 people are sitting at home, anxiously awaiting their fate, hoping for an eye clinic appointment that could save their sight.

Background

In 2019 the Welsh Government introduced the Eye Care Measures for NHS Outpatients (Eye Care Measures) after concerns were raised by RNIB Cymru in its report “Real Patients Coming to Real Harm” that ophthalmology services across Wales were struggling to manage key issues around capacity and demand. Patients were waiting far too long for both first ophthalmology appointments and for follow-up appointments but, because referral to treatment time targets focuses attention exclusively on new patients, those already in the system and in need of ongoing monitoring and treatment were deprioritized, regardless of clinical risk. This caused significant numbers of patients with treatable conditions to permanently lose their sight.

Wales was the first country in the UK to introduce these dedicated clinical prioritisation targets for ophthalmology. Introduction of the Eye Care Measures aimed to shift the focus away from traditional referral to treatment targets in favour of a more prudent approach to waiting list management and clinical prioritisation. Unlike referral to treatment time targets, the Eye Care Measures allow for clinical capacity to be directed to the most urgent cases to ensure that patients with the highest levels of risk associated with their condition are treated in a safe and clinically appropriate timeframe.

This is critical for ophthalmology because a significant number of patients need to be seen much sooner than the 26-week referral to treatment target to mitigate the risk of irreversible harm or blindness. Many also require follow up outpatient treatments at regular intervals.

Under the Eye Care Measures, all new and follow-up patients are categorised based on their clinical need and given an individualised target date for when they should be seen.

Due to the significance of the consequences of delayed treatment health board targets are for 95 percent of highest risk patients to be seen within their clinical waiting time. Each of these patients is real risk of suffering permanent and irreversible sight loss if their treatment is delayed.

Eye care measure data by health board – January 2025

Health Board	Total number of patient pathways assessed as being at highest risk of irreversible harm **waiting for an appointment**	Number of patient pathways assessed as being at highest risk of irreversible harm **waiting beyond target date**	Percentage of patient pathways assessed as being at highest risk of irreversible harm **waiting beyond target date**
Wales	161,902	80,826	49.9%
Betsi Cadwaladr	43,258	23,255	53.8%
Powys	2,047	611	29.8%
Hywel Dda	18,113	11,922	65.8%
Swansea Bay	21,121	5,143	24.4%
Cwm Taf Morgannwg	29,809	17,378	58.3%
Aneurin Bevan	29,463	16,094	54.6%
Cardiff and Vale	18,091	6,423	35.5%

Additional information

- RNIB Cymru (2024), Vision for a Fairer Future: Priorities for the new Cabinet Secretary for Health and Social Care
- Senedd Research Service (2024), "Eye Watering" – Ophthalmology Waiting Lists in Wales
- Institute of Welsh Affairs (2024), It's time to end avoidable sight loss in Wales
- National Assembly for Wales, (2019) Public Accounts Committee Management of follow up outpatients across Wales

- Wales Audit Office (2018), Management of Follow Up Outpatients Across Wales
- RNIB Cymru (2014), Real Patients Coming to Real Harm

Document ends.

Eitem 7.1

Pwyllgor Iechyd a Gofal Cymdeithasol

Health and Social Care Committee

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Sarah Murphy AS
Y Gweinidog Iechyd Meddwl a Llesiant

27 Ionawr 2025

Annwyl Sarah

Cyllideb Ddrafft Llywodraeth Cymru ar gyfer 2025-26

Gresyn nad oeddech yn gallu bod yn bresennol yn sesiwn graffu'r Pwyllgor ar gyllideb ddrafft Llywodraeth Cymru. Gobeithio eich bod yn teimlo'n well.

Er ein bod wedi gallu gofyn nifer o gwestiynau yn ymwneud â'ch portffolio i Ysgrifennydd y Cabinet, roedd rhai materion heb eu datrys a byddwn yn ddiolchgar pe gallech ymateb iddynt yn ysgrifenedig:

Iechyd meddwl

1. Mae eich papur tystiolaeth yn nodi bod angen i fyrddau iechyd wneud gwell defnydd o adnoddau presennol yn hytrach na cheisio cyllid ychwanegol ar gyfer iechyd meddwl. A allwch egluro pa gamau neu newidiadau penodol yr ydych yn disgwyl i fyrddau iechyd eu rhoi ar waith, a sut y bydd y rhain yn sicrhau y gall gwasanaethau ateb y galw cynyddol, a chynnal ansawdd gofal?
2. Mae'r cyllid iechyd meddwl sydd wedi'i neilltuo yn sicrhau bod byrddau iechyd yn cynnal lefel isafswm buddsoddiad mewn gwasanaethau iechyd meddwl. A allwch gadarnhau a oes unrhyw fyrddau iechyd wedi methu â chynnal y lefel isafswm buddsoddiad hwn ac, os felly, beth yw canlyniadau peidio â bodloni'r gofyniad hwn.
3. Yn absenoldeb Strategaeth Iechyd Meddwl ddiwygiedig, a allwch nodi blaenoriaethau Llywodraeth Cymru ar hyn o bryd ar gyfer iechyd meddwl, ac egluro sut y caiff y blaenoriaethau hyn eu hadlewyrchu yn y gyllideb ddrafft, yn enwedig o ran y meysydd darparu gwasanaethau sy'n cael eu blaenoriaethu, a'r cydbwysedd rhwng buddsoddi mewn gofal ataliol a chefnogaeth arbenigol i gleifion.
4. Yn ystod ei waith craffu ar gyllideb ddrafft Llywodraeth Cymru, dywedwyd wrth y Pwyllgor Plant, Pobl Ifanc ac Addysg nad yw'n bosibl pennu faint mae byrddau iechyd yn ei fuddsoddi mewn gwasanaethau arbenigol iechyd meddwl plant a'r glasoed (CAMHS), er gwaethaf amseroedd aros hir a heriau sydd wedi'u dogfennu o ran darparu ymyriadau amserol. Mae'r

wybodaeth hon yn hanfodol i ddeall pam nad yw'r canlyniadau a ddymunir wedi'u cyflawni, felly a allwch chi roi gwybod i ni sut y gallwch sicrhau bod lefelau buddsoddi yn ddigonol, a'u bod yn cael eu defnyddio'n effeithiol i wella canlyniadau heb y data hwn.

Iechyd plant

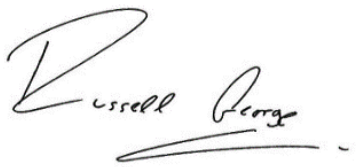
5. A allwch gadarnhau p'un a yw Llywodraeth Cymru wedi dad-flaenoriaethu iechyd plant yn y canllawiau ar Fframwaith Cynllunio y GIG /dyraniadau'r Byrddau Iechyd eleni, o ystyried y diffyg cyfarwyddebau penodol i fyrddau iechyd ddiogelu gwasanaethau plant (amlygwyd y rhain fel rhai yr effeithir arnynt yn anghymesur gan bwysau yn Fframwaith Cynllunio GIG Cymru y llynedd)? A yw hyn yn adlewyrchu rhagdybiaeth bod materion ar gyfer y grŵp hwn wedi cael sylw digonol?
6. A allwch gadarnhau pryd yr ydych yn disgwyl i'r datganiad ansawdd iechyd plant gael ei gyhoeddi. Ac, yn y cyfamser, a allwch roi rhestr fanwl inni o flaenoriaethau a ffrydiau gwaith ar gyfer yr arweinydd clinigol ar iechyd plant yng Ngweithrediaeth y GIG, ac egluro sut y mae'r gyllideb hon yn cefnogi eu cynnydd.

Cynllun iechyd menywod

7. A ydych yn credu y bydd y £3 miliwn a ddyrannwyd ar gyfer y Cynllun Iechyd Menywod yn 2025-26 yn ddigon i gyflawni'r camau gweithredu allweddol a amlinellir yn y Cynllun?
8. Gan fod hon yn brif flaenoriaeth i weinidogion, a yw'r dyraniad hwn yn ddigonol o ystyried ei fod yn cynrychioli cyfran gymharol fach o'r gwariant cyffredinol ar iechyd?

Byddai'n ddefnyddiol pe gallem gael eich ymateb erbyn dydd Gwener, 21 Chwefror.

Yn gywir



Russell George AS
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Sarah Murphy AS/MS
Y Gweinidog Iechyd Meddwl a Llesiant
Minister for Mental Health and Wellbeing

Llywodraeth Cymru
Welsh Government

Russell George AS
Cadeirydd
Y Pwyllgor Iechyd a Gofal Cymdeithasol
Senedd Cymru

6 Mawrth 2025

Annwyl Russell,

Ymddiheuraf nad oeddwn i'n bresennol yn sesiwn graffu'r Pwyllgor Iechyd a Gofal Cymdeithasol ar y Gyllideb Ddrafft a gynhaliwyd ar 16 Ionawr. Diolch ichi am eich cwestiynau. Rwyf wedi ymateb iddynt yn ôl eu trefn yn eich llythyr.

Iechyd meddwl

C1 Mae'r *Strategaeth Iechyd Meddwl a Llesiant Meddyliol* a'r *Strategaeth Atal Hunanladdiad a Hunan-Niweidio* newydd yn cael eu llunio yn y cyd-destun ariannol presennol a chyd-destun Cyllideb 2025-26. Nid oes gennym gyllideb na chynlluniau gwariant dangosol y tu hwnt i 2025-26. Byddant felly yn darparu cyfeiriad i'r system iechyd a gofal ehangach, ac i bartneriaid, ynglŷn â sut y gellir targedu adnoddau i gynnal iechyd meddwl da ac i atal hunanladdiad a hunan-niweidio.

Ein nod cyffredinol yw gwella mynediad at wasanaethau iechyd meddwl drwy gydol cwrs bywyd yn ogystal â darparu gwasanaethau sy'n canolbwyntio ar yr unigolyn ac sy'n cael eu harwain gan anghenion. Bydd hyn yn cael ei gyflawni drwy wahanol fodelau o ofal sy'n seiliedig ar dystiolaeth gan ganolbwyntio ar ymyrryd yn gynt. Bydd rhagor o fanylion yn cael eu cynnwys yn y strategaethau terfynol, y bwriedir eu cyhoeddi yn y gwanwyn.

Rydym wedi nodi disgwyliadau clir yng nghanllawiau cynllunio'r GIG i ddatblygu gwasanaethau iechyd meddwl, ac yn rhan o'r gwaith o gyflawni'r strategaethau, byddwn yn llunio datganiadau ansawdd ar gyfer iechyd meddwl i sbarduno'r gwaith o drawsnewid gwasanaethau. Mae Gweithrediaeth y GIG eisoes wedi datblygu manyleb gwasanaeth ar gyfer gwasanaethau iechyd meddwl plant a'r glasoed ac mae wedi'i chynllunio i leihau'r amrywiadau sy'n bodoli ledled Cymru ar hyn o bryd.

Rydym hefyd yn buddsoddi cyllid gwerth £2.2 miliwn yn flynyddol yng Ngweithrediaeth y GIG i ddatblygu Rhaglen Strategol ar gyfer Iechyd Meddwl, Rhaglen Diogelwch Cleifion a Rhaglen Atal Hunanladdiad a Hunan-niweidio. Mae hyn yn darparu adnodd pwrpasol i GIG Cymru ar gyfer sbarduno gwelliannau mewn perfformiad, ansawdd a diogelwch. Bydd y gwaith hwn yn parhau i helpu byrddau iechyd i fodloni safonau o ran amseroedd aros ar sail gynaliadwy a lleihau amrywiadau.

C2 Mae'r cyllid sydd wedi'i glustnodi yn darparu lefel wario na ddylai byrddau iechyd fynd oddi tani. Rydym hefyd wedi'i gwneud yn glir, pan fo arbedion effeithlonrwydd wedi'u gwneud, y disgwylir i'r rhain gael eu hailfuddsoddi mewn gwasanaethau iechyd meddwl. Gallaf gadarnhau nad oes yr un bwrdd iechyd wedi methu â bodloni'r isafswm buddsoddiad hwn.

C3 Mae'r *Strategaeth Iechyd Meddwl a Llesiant Meddyliol* newydd wrthi'n cael ei chwblhau felly nid yw wedi'i chyhoeddi eto. Fodd bynnag, rydym wedi cyhoeddi adroddiad cryno ar yr ymgynghoriad sy'n cadarnhau bod cefnogaeth eang i'r strategaeth ddrafft. Mae'r strategaeth ddrafft yn rhoi darlun clir ynghylch ein blaenoriaethau presennol yn ogystal â chanolbwyntio ar atal, ymyrryd yn gynt a darpariaeth iechyd meddwl fwy cydgysylltiedig a di-dor. Mae'r strategaeth ddrafft a'r adroddiad cryno ar yr ymgynghoriad ar gael yma.

Bydd y strategaeth derfynol a'r cynllun cyflawni yn rhoi manylion pellach ar sut y bydd hyn yn cael ei weithredu. Mae blaenoriaethau'r strategaeth eisoes wedi llywio'r Rhaglen Strategol ar gyfer Iechyd Meddwl sy'n ceisio gwella ansawdd cymorth iechyd meddwl a'r mynediad ato, yn ogystal â lleihau amrywiadau rhwng byrddau iechyd. Mae'n cynnwys rhaglen diogelwch cleifion a fydd yn canolbwyntio, yn y lle cyntaf, ar wella darpariaeth i gleifion mewnol.

C4 Mae swyddogion yn cyfarfod â byrddau iechyd yn fisol i fonitro ansawdd a pherfformiad gwasanaethau, gan gynnwys CAMHS. Mae gan fyrddau iechyd ragolygon a chynlluniau i wella gwasanaethau iechyd meddwl. Rydym yn gweld cynnydd da o ran lleihau amseroedd aros CAMHS.

Rydym hefyd yn datblygu cyfres o fanylebau gwasanaeth, ac fel y nodir yn yr ymateb i'ch cwestiwn cyntaf, bydd gwasanaethau CAMHS yn cael eu blaenoriaethu. Bydd y manylebau yn nodi cynnig craidd, egwyddorion, gofynion mynediad ac amseroedd ymateb gwasanaethau a fydd yn darparu templed y gellir monitro byrddau iechyd yn ei erbyn. Mae'r fanyleb o ran CAMHS wedi'i chwblhau ac mae byrddau iechyd wedi'u meincnodi yn ei herbyn. Mae byrddau iechyd wrthi'n llunio cynlluniau gwella ar gyfer cyflawni'r fanyleb a bydd Gweithrediaeth y GIG yn monitro cynnydd yn erbyn y rhain. Bydd rhoi'r *Strategaeth Iechyd Meddwl a Llesiant Meddyliol* ar waith hefyd yn amlinellu'r disgwyliad ar gyfer gwell data ar draws gwasanaethau iechyd meddwl, felly bydd gennym set ehangach o fetrigau i lywio ymarferion cynllunio ariannol yn y dyfodol.

Iechyd plant

C1 Nid yw iechyd plant wedi'i ddadflaenoriaethu. Mae'r blaenoriaethau strategol a amlinellir yn y fframwaith cynllunio yn berthnasol ar draws yr ystod oedran.

Rydym yn parhau i fonitro a helpu plant drwy'r Rhaglen Plant Iach Cymru sy'n darparu cynnig iechyd cyffredinol i bob teulu a chymorth wedi'i dargedu drwy Dechrau'n Deg, sef ein rhaglen flaenllaw ar gyfer y blynyddoedd cynnar. Mae'r ddwy raglen yn chwarae rhan hanfodol o ran gwella canlyniadau iechyd, hyrwyddo iechyd

plant a hyrwyddo llesiant i blant yng Nghymru.

Rydym wedi cyhoeddi model gweithredu unedig newydd i ategu'r fframweithiau nyrsio presennol mewn ysgolion yng Nghymru. Bydd yn estyn y Rhaglen Plant Iach Cymru bresennol drwy ehangu'r cynnig iechyd cyhoeddus cyffredinol i bob plentyn o oedran ysgol gorfodol, ni waeth beth fo'r lleoliad.

C2 Rydym yn gweithio gyda'r Rhwydwaith Iechyd Plant i ddatblygu *Datganiad Ansawdd ar gyfer Iechyd Plant* a fydd yn nodi ein disgwyliadau clir ynghylch y gwasanaethau o ansawdd uchel y mae disgwyl i fyrddau iechyd eu darparu.

Bydd gweithgarwch ymgysylltu â rhanddeiliaid yn digwydd dros yr haf a disgwylir cyhoeddi'r datganiad ansawdd erbyn diwedd 2025.

Iechyd menywod

C1 Mae'r *Cynllun Iechyd Menywod* wedi'i lunio gan y Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Iechyd Menywod, sy'n rhan o Weithrediaeth GIG Cymru, ac mae'n darparu glasbrint ar gyfer gweithredu'r *Datganiad Ansawdd ar gyfer Iechyd Menywod a Merched* a chanlyniadau gwaith y cam Darganfod. Bydd y cyllid newydd yn y Gyllideb Ddrafft yn helpu i gyflawni camau gweithredu'r cynllun, ac yn benodol sefydlu canolfannau braenaru iechyd menywod erbyn mis Mawrth 2026.

Mae cyllid ychwanegol wedi'i sicrhau i gynnal ymchwil iechyd menywod. Rwy'n falch iawn ein bod wedi gallu cyhoeddi cyllid pellach gwerth £3 miliwn gan Ymchwil Iechyd a Gofal Cymru i ddatblygu'r ganolfan ragoriaeth Ymchwil Iechyd Menywod Cymru.

C2 Mae'r *Cynllun Iechyd Menywod* yn gynllun uchelgeisiol 10 mlynedd o hyd ac rwy'n benderfynol y bydd yn ysgogi gwelliannau gwirioneddol o ran iechyd a chanlyniadau menywod. Bydd yn eirioli dros fenywod a merched yn y GIG ac yn eu grymuso i sicrhau bod eu lleisiau'n cael eu clywed wrth iddynt gael gofal iechyd.

Mae'n dangos sut y bydd y GIG yn rhoi ar waith y newidiadau sydd eu hangen i gyflawni'r *Datganiad Ansawdd ar gyfer Iechyd Menywod a Merched*.

Yn gywir

S. Murphy

Sarah Murphy AS/MS
Y Gweinidog Iechyd Meddwl a Llesiant
Minister for Mental Health and Wellbeing

Y Pwyllgor Deisebau

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Petitions Committee

Cadeiryddion y Pwyllgor Iechyd a Gofal Cymdeithasol; Pwyllgor yr Economi, Masnach a Materion Gwledig; y Pwyllgor Cydraddoldeb a Chyfiawnder Cymdeithasol; y Pwyllgor Plant, Addysg a Phobl Ifanc; Pwyllgor Diben Arbennig Ymchwiliad COVID-19 Cymru

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07 Mawrth 2025

Annwyl Gadeirydd

Deiseb P-06-1488 Sefydlu 'Cymdeithas Gofal' i Fynd i'r Afael â'r Argyfwng COVID Hir yng Nghymru

Trafododd y Pwyllgor y ddeiseb uchod yn ei gyfarfod ar 17 Chwefror, ynghyd â gohebiaeth gan Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol, a'r deisebydd.

Yn ystod y drafodaeth, nodais bwyntiau allweddol a godwyd yn fy nghyfarfod blaenorol â'r deisebwyr. Cydnabu'r Aelodau gwmpas eang y materion a godwyd, sy'n ymestyn y tu hwnt i gylch gorchwyl y Pwyllgor Deisebau. Roedd yn amlwg y byddai mynd i'r afael â'r pryderon hyn yn gofyn am strategaeth drawslywodraethol gan Lywodraeth Cymru.

O ganlyniad, cytunodd y Pwyllgor i ysgrifennu at y Prif Weinidog – gan gopïo Ysgrifenyddion Cabinet perthnasol i mewn, er ymwybyddiaeth – i holi am strategaeth draws-bortffolio'r Llywodraeth ar gyfer mynd i'r afael â COVID hir, yn enwedig mewn perthynas ag unigolion sydd naill ai'n ddi-waith, neu'n wynebu anawsterau o ran dychwelyd i'r gwaith, oherwydd COVID hir sydd, o bosibl, heb gael ei ddiagnosio.

At hynny, cytunodd y Pwyllgor i ysgrifennu at bwyllgorau pwnc perthnasol y Senedd i ofyn am ragor o wybodaeth am eich gwaith ymchwilio parhaus neu arfaethedig ynghylch dull strategol Llywodraeth Cymru o ymdrin â COVID hir.

Mae'r manylion llawn am drafodaeth y Pwyllgor ar y ddeiseb, gan gynnwys yr ohebiaeth a'r camau y cytunwyd arnynt gan y Pwyllgor, ar gael yma: P-06-1488 Sefydlu 'Cymdeithas Gofal' i Fynd i'r Afael â'r Argyfwng COVID Hir yng Nghymru.

Byddwn yn ddiolchgar pe gallech anfon eich ymateb drwy e-bost at y tîm clercio yn deisebau@senedd.cymru.

Yn gywir,

Carolyn Thomas AS
Cadeirydd

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.