GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Health and Social Care Committee
Senedd Cymru/Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

Sent by Email

17th April 2025

Dear Sir/Madam

Inquiry into Ophthalmology Services in Wales

Thank you for the invitation to contribute to this Inquiry. We would like to take this opportunity, in submission of our written evidence, to acknowledge the ongoing collaborative and supportive relationship we have with Welsh Government and colleagues from the NHS Executive, specifically in addressing the backlog and long waits for cataract treatment. We hope to continue this into 2025-26.

Our Ophthalmology service's Delivery Plan describes a series of very granular actions that are in progress to support delivery and transformation of our service. These actions seek to address immediate issues and risks within the Ophthalmology Service, as recorded on the Service's risk register, with the actions prioritised as high, medium or low. We have designed the actions in the Plan to correlate directly to the four strategic themes (Clinical Networks, Pathway Transformation, Organisational Reform and Sustainability Model) within the National Clinical Strategy for Ophthalmology.

Our Delivery Plan's component parts are cross cutting and can be segmented by sub-specialty (for example, Cataract, Medical Retina, Glaucoma) as well as each objective being linked to the service's risk register. Our prime areas of focus align directly with the areas of highest clinical risk and include:

1. The transfer of local anaesthetic, adult cataract operating to an improved environment with more reliable infrastructure and the development of GiRFT standardised pathways;
2. A commitment to develop a capital business case to increase capacity for cataract treatments, working further towards GiRFT standards;
3. Working with colleagues at Cardiff University to explore the potential of utilising resources and clinical capacity for the diagnostic care of Diabetic Retinopathy patients; thereby releasing capacity within the Health Board for more complex treatments for Medical Retina patients;
4. A commitment to increasing capacity for diagnostics and standardising on-going care pathways for Glaucoma patients;
5. Continuing with and learning from a series of harm reviews within the AMD service.

In addition, the Health Board is committed to undertaking a comprehensive rightsizing exercise to establish baselines in terms of workforce, demand, capacity and value-based outcomes. These are required to benchmark the Cardiff and Vale UHB Ophthalmology Service with comparator organisations and develop an understanding of what is required over the short

medium and long-term future to provide for our population, both in terms of local and regional delivery. We are approaching this by sub-specialty, with Glaucoma identified as the first requiring attention.

Within our evidence pack we have also submitted a position paper, previously submitted to the Health Board's Executive Board in September 2024. This sets out the position at the time in terms of size and length of the waiting list, waiting times, areas of risk and opportunities. We have provided updated waiting list numbers as an appendix to this letter. The opportunities identified in Glaucoma and Cataract operating are progressing, along with the harm reviews within the AMD service continuing.

The position paper references the commissioning of a review of our Acute Macular Degeneration Service from the Royal College of Ophthalmology in October 2024. The Review followed the process set out in the Guide to the Royal College of Ophthalmologists Review Service 2024 and included:

a) A review of activity, staffing and governance data regarding the ophthalmology service;
b) Interviews with key members of staff primarily involved in the delivery of the AMD patient pathway;
c) Other members of staff from the wider service;
d) A tour of the ophthalmology facilities at the University Hospital of Wales

The Report of the Royal College's Review will make recommendations for the consideration of the UHB's Executive Team as to:

- Any improvements to the redesigned pathways which may improve access to timely care.
- Whether the UHB's redesigned pathways are in line with best practice across the UK
- Whether the UHB is utilising the current resources of the department efficiently, including staffing.

The Report has yet to be received but is expected imminently, and the recommendations from which will be embedded into a Clinical Strategy for Ophthalmology, which we recognise is required to provide the vision and structure for the Service Delivery Plan and describe our aims for the next three to five years. We look forward to sharing this with you in due course.

Yours faithfully

PAUL BOSTOCK
CHIEF OPERATING OFFICER
CARDIFF & VALE UNIVERSITY HEALTH BOARD

cc **Michael Stechman, Clinical Director, Ophthalmology Directorate & Consultant General Surgeon**
Cath Wood, Director of Operations for Planned Care
Rhys Andrews, General Manager, Ophthalmology Directorate
Nesta Lloyd-Jones, Assistant Director, Welsh NHS Confederation

APPENDIX

Updated Ophthalmology waiting list numbers, by pathway type – as at 17th April 2025

1. Outpatient waiting list

CATARACT	3578
CORNEA	688
DRSS	866
GENERAL	179
GENERALP	323
GLAUCODTC	1502
GLAUCOMA	73
LASER/YAG	354
LUCENTIS	316
NEURO	316
NONE	2519
OCCULAPLA	1751
OCCULMOB	205
UVEITIS	122
VR	372
Grand Total	**13164**

2. Inpatient waiting list

$$X	10
CATARACT	1127
CORNEA	46
DRSS	24
GENERAL	14
GENERALP	133
GLAUCODTC	5
GLAUCOMA	32
HAND/WR/EL	1
LASER/YAG	2
LUCENTIS	1
NEURO	3
NONE	219
OCCULAPLA	236
OCCULMOB	41
VR	76
Grand Total	**1970**

3. Total waiting list with breakdown by weeks wait

Weeks wait	<12	12-24m	24-36m	over 36m	Grand Total
Pathway type					
CATARACT	0	1641	17	0	4902
CORNEA	0	350	12	0	799
DRSS	0	69	0	0	1047
GENERAL	0	51	6	1	233
GENERALP	0	90	16	0	476
GLAUCODTC	0	987	46	0	1571
GLAUCOMA	0	32	3	0	198
HAND/WR/EL	0	0	0	0	1
LASER/YAG	0	182	29	0	369
LUCENTIS	0	198	28	0	350
NEURO	0	128	110	5	350
NONE	0	672	19	0	3464
OCCULAPLA	0	938	226	0	2232
OCCULMOB	0	79	107	3	278
UVEITIS	0	24	2	0	143
VR	0	178	11	1	592
(blank)	0	0	0	0	
Grand Total	0	5623	632	10	17021

Report Title:	**Ophathlmology – The Size of the Challenge**								
Meeting:	**Executive Board**						**Meeting Date:**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**	
Lead Executive:	**Paul Bostock**								
Report Author (Title):	**Cath Wood / Rachel Thomas / Rhys Andrews**								

1. SITUATION

The Ophthalmology department within the Health Board is facing significant challenges related to demand and capacity, with long waiting times and significant backlogs across a range of subspecialties.

Over a period of years, demand and capacity for Ophthalmology has been mismatched. The backlog has grown year on year, as has demand for services.

The increase in demand has been driven by two factors: an ageing population and technological advances which mean there are now more treatment options available to patients for a wider range of conditions. Many of the sub-specialties within Ophthalmology, particularly Age-related Macular Degeneration (AMD) and Glaucoma, are time-critical and failing to treat these patients in a timely manner can cause significant harm including irreversible loss of vision.

The department has operated for many years without the necessary infrastructure and workforce to handle the volume of patients requiring care. This paper outlines in more detail the Health Board's position on our subspecialties and the areas of service delivery which require support. If no changes are made in our approach it will take us five or more years to rebalance demand and capacity within this service, which is not commensurate with the level of quality, safety or experience we seek to deliver for our population.

2. ASSESSMENT

2.1 Demand for Services

The Ophthalmology department faces significant challenges related to demand and capacity, exacerbating patient wait times and creating a substantial backlog.

Currently, there is a deficit between available capacity and patient demand, with 15,000 new outpatients awaiting their first consultation, with circa 3,000 consultation slots available and a further 21,500 patients requiring follow-up appointments.

In addition, current modelling anticipates a 6.4% growth (Royal College of Ophthalmology) in demand for Ophthalmic services by 2030, reflecting the natural population increase and the rising incidence of age-related eye conditions.

Sub-Speciality	Less than 12m	12 – 24m	24 – 36m	36m+	Totals	Total with Nones
Cataracts	2097	2258	0	0	4355	**5277**
Glaucoma	850	1210	634	0	2694	**2937**
Cornea	373	221	0	0	594	**705**
MR	643	19	0	0	662	**1066**
Neuro	127	320	1	0	448	**723**
Ocular motility	53	229	0	0	282	**282**
Oculoplastics	828	881	0	0	1709	**1950**
Paediatrics	255	29	0	0	284	**284**
VR	147	207	0	0	354	**563**
YAG	140	274	0	0	414	**414**
General	276	269	0	0	545	**545**
Genetics						**133**
Contact lens						**8**
ECLO						**0**
Orthoptics						**0**
None					2590	
Totals	**5789**	**5917**	**635**	**0**	**14931**	

Table1: New OPA by pathway type

Sub-Speciality	Less than 12m	12 – 24m	24 – 36m	36m+	Totals
Cataract	829	93	0	0	922
Cornea	86	25	0	0	111
General					
Glaucoma ODTC					
Glaucoma	243				243
Laser					
CL	3	5	0	0	8
Neuro	222	53	0	0	275
Oculoplastics	204	37	0	0	241
Ocular motility					
VR	90	119	0	0	209
MR	292	112	0	0	404
Genetics	83	49	1		133
Non Ophth	1				2
Totals	**2053**	**493**	**1**	**0**	**2548**

Table 2: Follow up by pathway type

2.2 Maximum Waiting Times

Urgent Cases (sight-threatening conditions): These should be treated as soon as possible, ideally within **24 to 48 hours**. This includes cases such as acute glaucoma, retinal detachments, and severe infections.

Routine or Non-urgent Cases: The maximum waiting time for non-urgent cases is typically set at **18 weeks** from the point of referral to treatment (as per NHS guidelines, which the RCOphth aligns with). This applies to conditions such as cataracts or early stages of glaucoma that are not immediately sight-threatening but still require timely intervention to prevent progression.

PATHWAY TYPE	Weeks Wait
CATARACT	125
CORNEA	121
DRSS	95
GENERAL	151
GENERALP	76
GLAUCODTC	147
GLAUCOMA	142
LASER/YAG	148
LUCENTIS	85
NEURO	160
NONE	164
OCCULAPLA	162
OCCULMOB	158
UVEITIS	92
VR	158

Table 3: Weeks wait at all stages

The table above illustrates current waiting times in weeks by clinical pathway in Ophthalmology for a new outpatient appointment. The current mismatch between demand and capacity means that potential harm has been identified to our patients that have waited longer than the Royal College of Ophthalmology recommends for their condition specifically in our Age-related Macular Degeneration (AMD) and Glaucoma pathways. Several more pathways are subject to an ongoing review.

2.3 Clinical Risk

2.3.1 Age-Related Macular Degeneration (AMD) Service

In the AMD service, 24 patients that were identified as “lost to follow-up” necessitating urgent harm reviews to assess the clinical impact of these delays. To date, 8 harm reviews have been completed, and an additional 4 reviews are scheduled for this month. The review process aims to identify any instances where delayed follow-up has resulted in deterioration of vision or other adverse outcomes, ensuring that patients can receive any necessary corrective interventions. The outcomes of these reviews will inform future service planning and ensure that high risk patients are appropriately prioritised.

2.3.2 Glaucoma Service

Glaucoma is a condition where the risk of irreversible sight loss is heightened by delays in diagnosis and treatment. Early detection and regular monitoring are crucial for preventing permanent optic nerve damage, as glaucoma is often asymptomatic in its early stages. Prolonged delays increase the risk that some patients may progress to advanced stages of the disease, resulting in permanent and preventable blindness.

Currently within Cardiff and Vale there are 3000 follow-up patients (Average two appointments per annum) and 2,600 new patients still awaiting their first outpatient appointment, some of whom have waited over three years to be see for the first time.

Given the prolonged waiting times, there is an urgent need to assess the clinical outcomes of these patients, many of whom may have experienced significant deterioration in their condition during waiting period. For glaucoma patients, ongoing harm reviews are being prioritised to determine the extent of potential sight loss and to prevent further damage, and the enabling validation work is currently being undertaken. Whilst this is the right thing to do, it does not solve the cause of the problem which fundamentally is a mismatch between demand and capacity.

In order to address these concerns and support the rightsizing of our service moving forward, Cardiff and Vale commissioned a service review by the Royal College of Ophthalmologists. The review will commence in October 2024, and will focus on improvements we can make to our existing pathways to improve access and maximize safety. The results of the review will be used to inform our approach to service delivery moving forwards.

2.4 GIRFT and Productivity Opportunities

In 2023 a GRIFT review which focused only on cataracts and glaucoma was completed. There are 46 recommendations from GIRFT, 2 are for both specialties, 34 are for cataracts and 10 are for glaucoma. Of the recommendations, some have been met in full however our recent change in footprint has meant that our position needs to be revisited.

The Cataract review highlighted some good practice, but also areas where improvements could be made. Timings of theatre and processes in the build up to surgery, as well as flow improvements on the day of surgery were identified, some of which have been implemented. This piece of work has halted temporarily as the review was conducted within Vanguard Theatres, which have since been de-commissioned.

Utilisation in cataract theatres has been reviewed, however, Vanguard being decommissioned means that we will need to re-review our cataract processes, pathway and flow in relation to the new theatre configuration. Post Vanguard, the service which currently priovides for both CAV and the South East region is temporarily being run from theatres 6 and 8 which is recognised to have a deleterious impact on throughput and as such permamanet accomodation for the team is currently being sought.

The Glaucoma recommendations highlighted gaps in adequate resourcing, dedicated sub specialty estate and workforce being required and SOP's and processes to be created. We have written and submitted a business case for the Bevan clinic requirements which would include photographer, technicians (HCSW) and optometrist to support treatments and reviews, as well as an additional consultant required. There is earmarked estate in UHL that could be converted and

utilised to set the Bevan clinic up, however the current department estate does not permit growth, nor is it suitable for high volume patient throughput.

2.5 Welsh General Ophthalmic Sevices (WGOS)

Other productivity opprtunities lie in WGOS4 – Referral Refinement/Monitoring whereby in using primary care optometry we have an opportunity to reduce historical demand by managing patients of higher risk. An Eye Care Delivery Group has been set up to oversee monitoring of this work the benefits of which have not yet been fully realised.

2.6 Regional Cataract Programme

Our cataract service is currently delivering Cataracts for both CAV and the South East region. CAV's position for RTT and capacity is sacrificed for the regional delivery and a desire within WAG to bring a level of parity on waiting times. In order to do this, it is imperative that regional waiting lists are pooled and access to services given in priority order by longest wait, irrespective of host Health Board. There are moves to enable this regionally, but until it does, regional working does not deliver the benefits to the Cardiff and Vale population that we would like to see.

2.7 Estates / Evironment

It has been proposed that the pemament estate solution for cataract surgery, glaucoma and IVT services should be UHL. This would provide us with a suitable space for us to revisist all the GIRFT recommendtaions and build these imporvements and efficiencies unto the delivery model at this location. The current estate facilities are not conducive to sustainably improving our service.

3. WORKFORCE AND CULTURE

Within the department there are a number of other issues being worked through including the current absence of a single means of recording the clinical record. Colleagues in IM&T are supporting the directorate in the roll out of OpenEyes and the termination of our contract with another supplier of digital record. There is also a cultural legacy to be acknowledged meaning engaging with clinicians is at times challenging, whereby clinicians have not felt heard or supported.

4. CONCLUSION

Due to the potential for harm, the sub-specialty considerations, complexity of regional service delivery and projected growth in demand due to an ageing population, a complete rightsizing execrise needs to be undertaken within Ophthalomology. The rightsizing work has commenced and is underpinned by detailed asessments of demand and capacity and incorporating the recommendations made by GIRFT, and outputs of the Royal College Review. This is a significant piece of work, and early indications indicate investment in the region of several million pounds will be required.

Recommendation:

Board is asked to

1. Note the contents of this report and the size of the challenge, and clinical risk carried within the Ophthalmology Service, and support in principal pursuing the work to understand what it would take to right size the service.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable