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Mr Peter Fox MS
Chair, Health and Social Care Committee
Welsh Parliament/Senedd Cymru
Cardiff Bay
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Sent by email

2nd July 2025

Dear Mr Fox

Thank you for the additional questions provided in your annex to your letter of the 9th June 2025. Many thanks also for the additional time allowed by your Committee Clerk for the submission of our response.

Our responses to your questions are contained in the following pages.

Yours sincerely

Catherine Wood
Managing Director for Planned Care

Michael Stechman
Consultant General Surgeon and Clinical Director for Ophthalmology

Service delivery

1. Changes have been made to the Welsh General Ophthalmic Services (WGOS) to enable primary care optometry to manage more patients in the community, thereby reducing demand on hospital eye departments. When do you expect to see the impact of these changes?

Cardiff and Vale UHB have migrated approximately 1,500 unfiltered glaucoma patients to community practices and have plans to migrate the remaining 1,100 patients by the end of the 2024-2025 financial year. Those that are able to be managed in the community are continuing to be monitored within this sector. The Health Board are also planning to operationalise our monitoring pathways for WGOS glaucoma patients already in monitoring/follow up within Hospital Eye Services (HES) or pre-existing community pathways with a transition over the coming months.

Within the Medical Retina sub-specialty, our criteria and pathways have been digitally and clinically developed with clinicians, digital, and primary care colleagues. We have plans to roll out these pathways over the coming months once community capacity and capabilities are understood. This will require a transition from current community pathways which are live and being run in partnership with Cardiff University School of Optometry and Vision Sciences.

Our pathways have been designed within the OpenEyes digital patient record and are ready to go live when staff have been trained.

2. What other strategies are in place to reduce demand on hospital eye care, specifically to help balance the priorities of seeing patients waiting for new appointments and those waiting for follow-up appointments, both of which are equally important? Additionally, how is emergency ophthalmology care coping, and has demand increased due to long waits?

The Health Board are currently managing the development and operationalisation of a Glaucoma outpatient diagnostic unit within the University Hospital Llandough (UHL) footprint. Our plans to date are aiming to go live in September 2025 which will deliver a high-throughput unit. This will enable timely care and monitoring for patients through best use of resources following models established in Moorfields and other exemplary Eye Hospital settings. This also aligns with recommendations made by GIRFT and the Pyott report.

Further diagnostic monitoring pathways in other specialties such as Cornea, Oculoplastics and Neuro-Ophthalmology are also in the early stages of scoping.

The Health Board are also actively engaging with partners at Cardiff University School of Optometry and Vision Sciences to relocate diagnostic imaging for our Diabetic Macular Oedema (DMO) service from the Hospital Eye Services (District General Hospital) footprint. This transfer of service will increase our capacity for Intravitreal injection treatment (IVT) services at the University Hospital of Wales (UHW) for high-risk AMD/DMO/RVO patient cohorts.

3. Do you believe the target, set out by the Ministerial Advisory Group, of performing 8 cataract surgeries in a 4-hour training session and 10 in a consultant-only session is achievable? What challenges do you foresee in meeting these targets?

The Health Board is faced with managing estates and infrastructure issues on a regular basis which have an impact on the delivery of high volume predictable complexity (HVLC) lists. This has become particularly evident in cataract surgery further to the decommissioning of the high-cost Vanguard mobile eye theatre unit which was funded by the South East Wales Regional Ophthalmology Programme.

8 sessions of cataract surgery are currently being transferred from within the UHW day theatre footprint into existing theatre space within UHL, where our plans are to deliver 7 cataracts per list with an expectation of meeting the GIRFT target of 8-10 cases per list during Q3 of this financial year. The Health Board was achieving these levels of activity prior to removal of the Vanguard mobile eye theatre unit, therefore these activity plans are credible and feasible.

In order to treat higher volumes of patients, the Health Board's capital project for twin cataract theatres will need to be supported. This will ensure that environmental factors allow for the delivery of High Volume All Complexity (HVAC) and High Volume Low Complexity (HVLC) as standard across all local/topical anaesthetic lists.

4. How prepared are you to establish Local Theatre Optimisation Boards, and what support do you need to ensure their effectiveness?

The Health Board are fully engaged in the 6.4.2 theatre booking and scheduling process which is managed and monitored by the Directorate of Peri-Operative Care. Improvements in theatre utilisation have already been realised, with a recent 8% improvement of in-session utilisation.

The Directorate of Peri-Operative Care are engaged with their GIRFT recommendations, and colleagues across the Health Board are working collaboratively to ensure efficiencies and improvements are sustainably met.

This programme of work is being delivered through the recently established Theatres Tomorrow Programme.

5. What are your plans to handle the projected 6.4% increase in demand for ophthalmic services by 2030? What support do you need from the Welsh Government to help you provide a permanent solution and ensure the long term sustainability of eye care services?

The Health Board are fully engaged in ensuring efficiencies and improvements can be achieved, with enablers including treating 7 cataract patients per list, reducing DNA rates, and targeted overbooking of outpatient clinics.

The largest barrier for the Directorate is the infrastructure to deliver the service. Therefore, we would welcome the support of Welsh Government to support the development of a fit for purpose eye unit to allow our services to grow and meet the ever growing currently unmet demand for ophthalmic services.

A "rightsizing" paper is currently being worked up to determine the service model for our sub-specialty Ophthalmology services. Our ask to Welsh Government is to support our plans to develop the service, based on an efficient and best utilised workforce across all specialties in order to create a sustainable service that does not require short term, high cost variable funding to address gaps in demand and

capacity. Short-term fixes have previously required a very challenging turnaround and does not deliver a sustainable solution.

6. The Committee has heard about the importance of commissioning equipment and ensuring it is properly maintained. Is your health board setting aside an appropriate part of its budget to replace essential equipment in a timely fashion?

There are two methods employed within the Health Board to enable timely commissioning and maintenance of equipment. For Ophthalmology, a Managed Service contract is in place with Alcon to replace and maintain equipment. Should issues arise outside of this, the Health Board has an Annual Discretionary Capital Budget for which any ad-hoc requests outside of the Alcon contract arise through the Directorate Risk Register. There is then a well recognised process in place within the organisation to prioritise discretionary capital to support applications according to clinical risk.

7. Given the current challenges in ophthalmology, including shortages of ophthalmologists and optometrists, imbalances in sub-specialties, and the need for effective collaboration with HEIW and universities, what comprehensive strategies is your health board implementing to ensure a sustainable and well-equipped workforce?

The Health Board are fully engaged with the All Wales Clinical Implementation Network (CIN) and their recommendations around workforce and job descriptions/roles. We have made attempts to obtain best practice models on evidence-based outputs, to influence our future modelling of the service and have been exploring service models being used in other NHS organisations in Wales and England. We have also commissioned reviews by the CIN and Royal College of Ophthalmology to obtain recommendations for improvement.

We are and have been working closely with our partners at Cardiff University School of Optometry and Vision Sciences to utilise their skilled workforce and support the upskilling of community optometrists. Prior to the implementation of WGOS we had a number of pathways set up with the University which the WGOS pathways replicate and through our ongoing collaboration we are hopeful that the range of services will grow and develop.

As outline above, we are engaging and making plans to partner with the University additionally to support the movement of services that do not require to be undertaken in Hospital Eye Services, such as DMO diagnostics.

Finally, growing our imaging and technical workforce to support and release our medical workforce time is another key area of development for us.

8. Are any vitreoretinal surgeons currently being trained in Wales, or are you still dependent on tertiary centres like St. Paul's Eye Unit in Liverpool and Bristol Eye Hospital for these treatments? (i.e. are health boards collaborating to ensure treatment and care for complex eye conditions are available within Wales, or is relying on English services the best option)?

Cardiff and Vale UHB provide the VR service for South East Wales and we would like to grow our VR service to further support the region and repatriate the current spend and activity going to NHS England Trusts back into Wales.

There is a requirement to grow the VR service to meet the demand in our region and we have requested that the South East Regional Ophthalmology Programme consider this service as the next area to focus on delivering regionally.

The Health Board have recently employed a new full time VR consultant in November 2024 and engaged in a succession planning exercise to mitigate our imminently retiring VR workforce over the coming years.

Promisingly, two high calibre VR trainees have recently undertaken training within the Health Board; the current position being one individual currently undertaking a fellowship and the other individual approaching completion of ST7 of training. Both individuals are geographically based in Cardiff.

Our current emergency theatre lists are undertaken on Monday, Wednesday and Friday to meet 48-hour requirements of care; however, we would like to expand this and increase our throughput in Emergency Eye Care to support this.

9. Dr. Pyott noted in his review of Eye Care Services that there had been challenges engaging clinicians. Is this still a problem, and if so, how are you addressing these challenges through the Clinical Network?

The Health Board has held conversations on this matter with the national CIN as part of our review, as well as through the Clinical Lead. Updates to historic, long established contract recommendations and ways of working should be reviewed and we have made this clear in our discussions with the CIN.

The CIN and South East Wales Regional Programme have suggested engagement sessions with the clinicians on Friday afternoons (in line with the national weekly teaching session) to be held quarterly.

Locally, the Health Board have appointed a new Clinical Director from outside of Ophthalmology to bring an external viewpoint aligned to other specialties ways of working, which has improved the levels of engagement within the department. We continue to work with our clinical colleagues to try to improve the service and secure support to redesign pathways and some of the wider challenges facing Ophthalmology. We feel these challenges stems from a number of years where the demand on services has been allowed to grow, but perhaps not met the capacity requirements in a substantive way, which has caused a lack of belief that there is a desire to recurrently resolve the resulting gap.