

Inquiry into Ophthalmology Services in Wales

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?**

The benefits of the WGOS 4 initiative are beginning to materialise.

The Glaucoma element of the WGOS 4 pathway was introduced across Hywel Dda in September 2024. This involved a desktop review of all low-risk Glaucoma referrals, to identify patients suitable for monitoring in Primary Care and to date, 292 Glaucoma patients have been discharged to Primary Care. Since implementation, 578 patients' care pathways have been delivered by our Primary Care based Optometrists.

Prior to implementation of WGOS 4, it was identified that 20 practices were suitably qualified to deliver the filtering and monitoring pathway. The Medical Retina element of the WGOS 4 pathway was introduced across Hywel Dda in December 2024. This pathway involved an already established consultant connect platform, which has identified patients suitable for monitoring in Primary Care and to date, 466 Medical Retina patients have been discharged to Primary Care.

The WGOS 5 pathway allows Optometrists to prescribe in Primary Care. This was implemented in January 2024 and is provided by 20 practices across the Health Board area. During 2024/2025, there were 4,806 episodes of care delivered under this pathway in Primary Care, with many not requiring accessing care via Hospital Eye Services (HES).

The introduction of these services has allowed patients to be seen in Primary Care and closer to home and has already positively impacted on the quality of patient experience and timeliness of appointments. In total, the introduction of the WGOS pathways is supporting the clinical management of over 5,747 patient contacts away from the HES.

- 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?**

Other strategies adopted by the HB include,

- Referral refinement is undertaken at the point of triage, by four trained Optometrists, who review all referrals to draw out the moderate and low risk patients and advise next steps. All high-risk patients are then triaged by an Ophthalmology Consultant. All patients deemed as high risk within two weeks are then sent to the Emergency Eye care clinic for review.

- R1 capacity, new capacity and follow up capacity is built into each clinic template. Additional WLI clinics are secured for both Eye Care Measures and Ministerial Measures targets to increase capacity.
- Validation of the follow up waiting lists is ongoing with the 100% delayed category clerically validated, drawing out potential patients who can be converted to SOS/PIFU. These patients are then sent for Clinical validation to ensure the correct pathway has been selected prior to outcome.
- The national Clinical Implementation Network (CIN) guidance has been circulated to all consultants and discussed in our monthly Consultant meeting and Quality and Safety meeting, to ensure compliance from all clinicians.
- The Hywel Dda UHB Ophthalmology service is piloting a DNA prediction tool to inform whether clinics can be overbooked, to increase capacity.

Emergency eye care service capacity is challenged with the demand of urgent referrals under two weeks and required follow up appointments for this service. Additional follow up clinics for Emergency Eye care services have been secured through the outpatient model. Our triage doctors now triage on site, which has contributed to increased capacity to respond to the most urgent patients.

To further support sustainability, the service is planning the development of Emergency Eye Care practitioners, which will release the medical clinicians from Emergency Eye Care pathways to support clinic capacity in their respective sub-specialty pathways.

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 target to reach eight cataracts in a surgical session can be achieved with the right infrastructure support in place.

The Health Board currently delivers seven to eight cataracts at our Amman Valley Hospital (AVH) unit due to the high flow principles applied in this pathway. The One stop Pre-assessment clinic has helped with the high flow principles. All patients who attend one stop clinics receive a complete work up for theatre, inclusive of testing, preassessment and consent. This has generated efficiencies on the day of theatre. We are pursuing opportunities to replace the existing microscope at AVH, which will further improve productivity at the unit.

Throughput via our main theatre lists at Glangwili Hospital average five to six patients, due to the inclusion of more complex patients and challenges re theatre staffing availability. Our theatre optimisation project is reviewing the theatre staffing model to ensure more consistent provision of theatre nurses dedicated to cataract lists, alongside improvements to the operational policies and pathways supporting the flow of patients between the ward area and the theatre suite. Once resolved, these factors will support progress towards target levels of throughput via our main hospital lists.

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

With the recent restructure of our operational function and the establishment of a new Clinical Care Group operational structure, a new Theatre Optimisation Board has been established to drive productivity towards GIRFT recommended standards, and address long standing workforce challenges.

As a Health Board, we have worked closely with the former NHS Executive in support of our theatre optimisation improvement at AVH and look forward to continuing this engagement with the new Performance & Productivity Unit.

Over the longer term, review and development of a bespoke theatre management information system is a priority for the Health Board.

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 Hywel Dda UHB Ophthalmology Service continues to experience a significant workforce challenge, which has necessitated the continued reliance on the independent sector in recent years, to help maintain progress in reducing waiting lists volumes and length of wait.

We are pursuing a range of complimentary strategies to improve the sustainability of our services as we face future forecast increases in demand:

The Hywel Dda UHB Clinical Services Plan review has identified Ophthalmology as a fragile service and our teams have considered a range of options to reconfigure the service that meet the needs of the future. Alongside service transformation priorities, options also consider opportunities to reduce the number of locations from which care is currently delivered, which in turn will concentrate clinical expertise and support service efficiency and consistency.

With implementation of CIN guidance, our teams will reduce follow up demand, releasing clinical time to prioritise our sub-specialty pathways.

In parallel, we are reviewing our workforce model to support the development of extended roles within the team, appropriate to the needs of particular pathway groups. This includes expanding our nurse injector workforce in support of our IVT pathway.

The development of the WGOS services will ensure that patients who can be monitored and treated in Primary Care are managed outside of the HES, reducing demand on the service.

For 2025/26, £3.2 million has been invested recurrently to expand support of our R1 (high risk of sight loss) cohort of patients to increase medical retina delivery within the intra-vitreous service. Non recurrent funding has been secured for cataract delivery in line with the Ministerial Measures.

Alongside these local initiatives, we are committed to the development of regional pathways and are actively working with Swansea Bay UHB in support of a Regional Eye Care Programme, overseen by the Joint Committee established by both Health Boards. This work will prioritise the development of regional subspecialties, initially for Medical Retina, VR, Glaucoma, Cataracts and Paediatrics. This will enable consultants to work as part of a team of Consultants for each sub-specialty, moving away from single handed consultant models to build more sustainable services.

In order to continue to progress towards a sustainable Ophthalmology service in the future, further national coordination is required to drive access to training in Wales both for medical and nursing staff, who often have to travel to England to access courses relevant to their development. It would also be helpful to continue to develop guidance through the CIN programme on safe staffing levels, training, competency pathways, waiting list management etc so we standardise the approach to Ophthalmology throughout Wales.

Facilities and equipment

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?

Discretionary capital resources across all Health Boards are limited and the Health Board has to prioritise the needs of the Ophthalmology service alongside all other services and priorities.

The Health Board currently faces a significant capital infrastructure backlog, which in part, along with related service and workforce pressures, has influenced the Health Board's longer term strategic thinking and the need for changes to the configuration of our acute hospital estate infrastructure for the longer term.

Equipment replacement priorities of all services are assessed in a consistent, risk assessed manner on a continuous basis.

Workforce

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?

Within the Health Board, we are pursuing a range of complimentary workforce development strategies:

- Access and support to the Certificate of Eligibility for Specialist Registration (CESR) pathway within the HB. There are currently two Specialist and Associate Specialist (SAS) doctors working towards their exams in order to apply for this pathway. The Service has circulated the requirements and competency framework to all SAS doctors to work towards Specialist posts where CESR is not intended. The Health Board is looking to support the introduction of Specialist posts to support Ophthalmology fragility.
- Securing junior doctors training
- Development of Optometrists in the community continues to be supported by secondary care for WGOS pathways. One secondary care Optometrist has been secured with advanced paediatric and medical retina training. A further secondary care Optometrist post is being considered for paediatric delivery. Contracts and competency pathways are being developed for 3 Optometrists to undertake laser training, to increase laser delivery within the HB.
- Dual roles have been developed for the Orthoptists to include paediatrics, adult motility and intravitreal injections, with two orthoptists now delivering dual roles and a third on-boarding.
- An SBAR is being developed to detail the requirements needed to develop advanced roles for emergency eye care nurses. This will release Clinicians from Emergency Eye Care triage back to clinics and intravitreal injection delivery.

8. Dr Pyott's report noted the fragility of service in South West Wales, specifically due to consultant ophthalmologist shortages. Have these issues been resolved, and are posts still hard to fill?

Whilst consultant ophthalmology posts continue to be hard to recruit into, considerable work has been undertaken to support the CESR pathway within the Health Board. This has resulted in the development of a further substantive consultant, enabling five substantive consultants in total. The service is supported by two locum consultants, one of whom is considering the CESR pathway.

To support further progress, two consultant vacancies have been prioritised for regional recruitment in partnership with Swansea Bay UHB, with the objective of recruiting into VR and Medical Retina subspecialties.

Specialist posts are being considered for more remote areas within the HB, where consultant support is currently via remote means only.

9. 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)?

The Health Board has one VR consultant, and we are partially dependent on the Bristol Eye Hospital during periods of annual leave and absence. The proposed Regional VR consultant post will be advertised in Swansea Bay University Health Board (SBUHB) with clinics delivered out of HDUHB and theatre delivery in SBUHB. The aim of this recruitment will be to move towards a regional VR model, supported by four VR consultants, which will give opportunity for training (HUDUHB currently has two SAS doctors training in VR) and consideration to a VR out of hours service in SBUHB.

10. 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 introduction of a new management team structure in July 2023 has generated improved engagement within and between the wider clinical and service team and the development of a multi-disciplinary approach between clinicians, nursing staff, primary care optometrists, orthoptists, administration and managerial staff. This has included clinical engagement in a regional approach with SBUHB, which is developing at pace.

Within our Ophthalmology service, we now have a Consultant Clinical lead, a Consultant CIN lead, a Consultant Regional Lead, a Consultant Training Lead and Subspecialty leads for regional work.