

NATIONAL CLINICAL STRATEGY FOR OPHTHALMOLOGY

DELIVERING THE FUTURE OF OPHTHALMOLOGY IN WALES

Report 1- Strategic plan

September 2024

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Foreword

The diagnosis for Welsh ophthalmology services has never been clearer. More than one in 20 people across the country are waiting for an appointment, departments are struggling to fill consultant roles, and archaic digital and physical infrastructure are creaking at the seams.

Ophthalmology services are under pressure across the whole of the UK, but the situation in Wales is particularly alarming. Over the last decade, the number of people waiting for an ophthalmology appointment increased by 169% in Wales and – unlike in England or Scotland – there is no sign that waiting lists are starting to come down.

If this were a patient in our clinics, we would urgently be planning a course of treatment to prevent their condition worsening and ultimately return them to full health. The same clear-sighted evidence-led approach must now drive us towards the major reform we know is needed to improve eye care services in Wales for the long term.

This National Clinical Strategy for Ophthalmology offers a compelling, clinically-led case for a new model of eye care. By organising NHS ophthalmology services around local patient need rather than administrative boundaries, we can better target investment and prioritise integration and efficiency to deliver more high-quality care.

Alongside reform must come investment. Nowhere is this more urgently needed than for our outdated physical and digital infrastructure. A recent Royal College of Ophthalmologists survey of clinical leads found that no ophthalmology department in Wales has a well-functioning electronic patient record (EPR) system, interoperable patient records with optometry, nor an electronic eye care referral system. Respondents also highlighted crumbling and ill-equipped estates, with one unit reporting a lack of ultrasound or pan-retinal photocoagulation laser and microscopes operating at the end of life.

I am, therefore, very pleased to see this strategy commit to an in-depth review of estates, essential maintenance to clinical and non-clinical areas, an expansion of the size of ophthalmology departments, and the co-location of clinical and administrative services as appropriate. Likewise, commitments to implementing a Wales-wide EPR, networked eye care systems and a plan to replace end-of-life equipment will all help Welsh ophthalmology catch up with recent technological innovations and be well-placed to incorporate future advances.

As well as a much-needed focus on infrastructure, investment in the staff we need to deliver care is paramount. Wales has just 1.97 consultants per 100,000 population – well below the minimum three that we recommend are needed to deliver hospital ophthalmology services. As the population continues to age in the coming decades, patient demand will grow. The strategy's recommendation for an additional 36 ophthalmology training places phased over seven years will deliver the workforce needed to meet this expanding demand. We look forward to working with Health Education and Improvement Wales to put this into action.

Fully utilising primary care capacity is the other crucial part of the workforce equation. Ophthalmology and optometry colleagues already work closely in Wales, so it is right the strategy pinpoints building on these foundations as a priority. Our joint vision for integration provides a practical blueprint for how this can be achieved.

At its heart, regionalised eye care will mean working across existing boundaries to pool services and allocate resource in line with local need. While the strategy considers alternatives to such service reform to help tackle low-complexity lists, it is right to stress that without suitable commissioning arrangements our already fragile NHS ophthalmology service in Wales may be destabilised.

With our specialty's commitment to innovation and given the scale of the challenge we face, ophthalmologists in Wales are keen to do things differently and play a central role in delivering this strategy. With Rhianon Reynolds as Llywydd of The Royal College of Ophthalmologists and national clinical lead for ophthalmology as a principal author of this strategy, I have full confidence that clinicians' voices will be heard both now and into the future.

This National Clinical Strategy for Ophthalmology sets out a clear, ambitious vision for a new way to deliver eye care, underpinned by sufficient capital investment, reforming how and where we deliver care based on local need. Above all, this strategy provides a much-needed strategic direction for the development of ophthalmology services. Its ambition must be met if we are to tackle our crisis in ophthalmology. I look forward to this work developing in partnership with clinicians in Wales over the coming months and years.

Professor Ben Burton
President, The Royal College of Ophthalmologists



Executive Summary

Secondary care Ophthalmic services require urgent and focussed transformation to avoid crisis

Waiting lists continue to grow beyond current capacity, and patients continue to come to significant harm due to a historic lack of operational prioritisation of ophthalmic services—and a co-ordinated commitment to change across the National Health Service (NHS) in Wales. Focus at all levels has been on meeting transient targets with short term fixes rather than a sustained and maintained change in how care is provided. Even with efficiency and productivity opportunities seized, there is an imbalance between demand for hospital eye care and available capacity in several sub-specialty areas.

The result of delays in treatments, monitoring and care can be catastrophic for patients who may lose vision irretrievably, facing the rest of their life without the most fundamental of senses, never seeing loved ones faces again, never being able to read a book, or coming to other harm as mobility becomes treacherous. The impact on mental health of vision loss cannot be underestimated with levels of depression being significantly higher in those with a vision impairment.

In recent years there has been considerable focus on transformation of primary care eye care services leading to radical and groundbreaking change that will allow optometrists to work to the top of their skill set in primary care. This trailblazing approach to eye care provision has put Welsh eyecare in the spotlight of the rest of the UK as shining example of best practice. However, the reality is that the exceptional work and effort that has been directed to primary care services cannot alone address the potential crisis in secondary care as a substantial number of patients still require the more complex eyecare provided by Hospital Eye Services (HES).

HES need changes that are just as radical, groundbreaking and trail blazing as those in primary care. This would allow for an exemplar whole pathway eye care service to be modernised and transformed, capable of meeting the needs of patients and growing demand over the next ten years and beyond.

The National Clinical strategy for Ophthalmology (NCSOphth)

Evidence is key to understand why services in Wales are not currently working. This involves exploration of current needs and barriers to achieving change and solutions to tackle the impending crisis. Working with health boards and centrally held data, attempts have been made to accurately determine the current demands on the service and the capacity gaps that exist and are contributing to the ever-growing waiting list. Consultation with key stakeholders allowed an understanding of working conditions of those at the coalface and how transformation of care could look.

Waiting times for the service are lengthy as the population ages, service demand is increasing by approximately 1% per year on the background of the ongoing pandemic backlogs. Workforce is fragile with many sites, particularly in the West, facing significant recruitment and retention issues across the entire workforce and rely on locums and agency staff to fill crucial gaps in skillsets.

Estates are cramped, in a poor state of repair and space allocated has not expanded in line with demand. Capital investment in equipment is ad-hoc with many sites relying on critical diagnostic and treatment equipment that is at the end of its useful life.

Welsh Ophthalmology remains a digital desert with minimal digital architecture specifically to support eyecare services which are extremely data heavy, second only to radiology in data demand. There remains no national electronic patient record or electronic referral system that meets eyecare needs, despite previous investment and support from Welsh government and mandates from Health Inspectorate Wales (HIW). This limits the transformation capability of services, limits granular understanding of services and limits communication between HES and primary care allowing WGOS reforms to reach full potential.

It is in the gift of Eyecare in Wales to find a solution

From understanding the way eyecare is currently delivered and the substantial barriers that currently exist, four main strategic themes have been developed to address this challenge head on and transform HES:



These four underlying strategic principles will drive change and underpin the future of HES. Organisations need to change in the way they approach eyecare and ensure it is prioritised in delivery of service. There needs to be clear commitment to the move to a true regional delivery model, not a nod to collaborative working, with robust governance and financial change to support clinical care. This radical infrastructure change needs to be the first step to ensure clinical and pathway transformation has a scaffold to allow it to grow. This is fully aligned with the Welsh Government and NHS Executive planned care programme for a National Clinical strategic approach to care following success of work carried out to develop, and now implement, the National Clinical Strategy for Orthopedic Surgery (NCSOS). There is also an ask of the Ophthalmic workforce to meet this challenge with a renewed vigour for change and an eye to the future. Development of clinical networks across Wales will address the discrepancies in care that currently exists and ensure that clinicians are working an evidence based, efficient and sustainable way. Development of All Wales treatment protocols will add weight to clinicians to apply consistency to practice and ensure that health boards have the reassurance that services are developed with the highest level of clinical oversight and should limit challenges to delivery from non-clinical partners.

The future of eye care in Wales is a move towards a fully integrated pathway where patients move seamlessly between points of care. By ensuring pathways are robust, clinically lead and implemented effectively, eyecare in Wales can provide both equality and equity for the patients that need it. By

working within HES, across primary care and also with patient support services, the current challenges that face patients can be addressed whilst ensuring that the highest quality of care is delivered. Finally, these changes cannot stand without considerable commitment and investment in creating a sustainable future for the delivery of eye care. Our workplaces must be fit for purpose and whilst optimising current estates is recommended the only way to move forward is with 3 regional delivery centres where complex care is centralised on a regional footing and provided to the very highest quality. Local delivery centres can provide higher volume and lower complexity of care that still requires the oversight of HES, whilst community provision of those falling into the very lowest risk category can be provided by our primary care partners under the WGOS reforms. Teaching will then be delivered to the highest of standards and, in collaboration with Academic institutions, Wales can develop into providing the same world class clinical research, alongside the cutting-edge basic science vision research that is already carried out.

This overarching strategic approach to the way HES needs to be delivered to survive will be followed with more granular detailed reports addressing specific areas such as workforce and training and each of the sub-specialties within Ophthalmology. However, the four underlying principles will be adopted at each point to ensure a consistent, achievable and sustainable endpoint.

Commitment at every point in the delivery pathway is needed. From Government support, Health Board executives, clinical bodies and patient groups, full support of the future way forward for HES in Wales is needed to drive transformation and avoid impending crisis.

Introduction and Background

Our sight is precious. Vision loss is the ailment people fear most, with up to 50% of the population cite vision loss as the worst possible health outcome (1) Not surprisingly, those with vision loss can experience a marked deterioration in mental health; levels of depression are significantly higher in those with vision impairment, an effect that is compounded in those living in the highest levels of deprivation (2) The result of delays in treatments, monitoring and care can be catastrophic for patients who may become irreversibly blind, facing the rest of their life without the most fundamental of senses, never seeing loved ones faces again, never being able to read a book, or coming to other harm as mobility is impaired. Conversely, ophthalmic treatment can deliver some of the best outcomes in terms of quality-of-life gains provided that these treatments are applied in a timely fashion. In many conditions once the window of opportunity to intervene has passed the harm cannot be undone.

The complexities of the delivery of an efficient, effective and sustainable Eyecare service make it unlike other healthcare specialties. These differences are an important part of what makes Eyecare unique, both in its challenges and opportunities. Eyecare describes a service not a specialty. Eyecare has a number of highly trained healthcare professionals currently working within either primary or secondary care services. Primary care Eye services (PCES) are provided by community-based optometrists, with minimal care provided by General Practitioners. Optometrists have qualifications which allow them to be registered with the General Optical Council (GOC) and most are members of the College of Optometrists. Secondary care or Hospital Eye services (HES) are Ophthalmology Consultant led units, supported by a multi professional workforce. Consultant Ophthalmologist are medically trained and registered with the General Medical Council. They will have undertaken a recognised training programme allowing them to be on the specialist GMC register and most are also members of the Royal College of Ophthalmologists. An effective Eyecare Service will have both aspects of the service performing to the highest levels. They are two interdependent facets of a fully integrated eyecare pathway.

Over recent years Enhanced optometric services have been developed with the introduction of further higher qualifications for optometrists, allowing them to upskill and provide care that previously would have required referral into secondary care. In Wales, this change has been embedded into legislation with the introduction of the new Optometry Contract in September 2023 in a response to the NHS Wales Eye Health Care Future approach for Optometry services and Optometry: Delivering a healthier Wales which was developed the Welsh Optometric Committee (3). This is a groundbreaking approach to eyecare, and over the coming years will see patients at the lowest risk of vision loss that still need ongoing care receiving this care within PCES closer to home, akin to stable low risk patient with diabetes being looked after by their GP rather than a hospital Diabetic consultant. This is widely welcomed and will no doubt improve care for these patients.

Sadly, there will continue to be patients who are at much greater risk of vision loss and those that require complex care that can only be provided by HES. Within the HES in Wales this high skilled complex care is currently failing to provide the quality of care that is needed. This is multifactorial in nature and unless urgently addressed we will see increasing numbers of patients losing vision. Given the urgency of the need to address the potential looming crisis in HES this strategy will focus on

changes needed in secondary care services to facilitate the same level of change seen in PCES to ensure a fully balanced and functioning Welsh Eye Care Service.

The value of vision

Adding to the urgency and complexity of eye care is that many complex eye conditions are asymptomatic until it is too late, and the patient has permanent vision loss. It is the ongoing care of these patients that prevents blindness or extends the years of functional vision, however, to preserve sight the patients are often part of the secondary care service for the rest of their lives and as life expectancy increases this extends the



burden on services. Whilst low risk patients can be monitored in the community as part of the WGOS contract reforms, those at the highest risk need to remain under the highly specialist and skilled care of a consultant Ophthalmologist and are simply not safe to be managed in any other way.

Our sense of sight is responsible for most of the information we absorb from the world around us. Many of the movements we perform, tasks we complete and personal interactions we make rely on vision in some way. Even our sleep schedules are affected by our visual system.

The impact of sight loss and sight impairment is substantial and affects every part of life including simple personal care tasks, socialising, and undertaking hobbies and interests. The mental health impacts cannot be underestimated, feeling of isolation, anxiety, loneliness and depression are extremely common and considerably erode quality of life for patients and their families⁵.

"I have been waiting for 2 years for my cataracts operation and during that time I've, lost independence and had to rely on others as my good eye suddenly became my bad eye and couldn't drive, watch tv or read. I feel really lonely and isolated and I only go out when I have to"

"My sight has become so bad I've had to give up work and stop driving and it has really affected my ability to care for my family. I'm struggling to support my disabled father and my partner is having cancer treatment, I really worry how we'll cope if my sight gets worse"

"My mental health has impacted greatly on my life, I am no longer able to drive and struggling in work - can't go on much longer and worried how I can manage financially if that happens"

"I knew my mother had glaucoma but thought that I was fine. When the doctor told me I had permanently lost my peripheral vision it was devastating"

“My baby was premature but healthy. It was a shock when I heard he needed treatment for retinopathy of prematurity. I didn’t know that could happen”

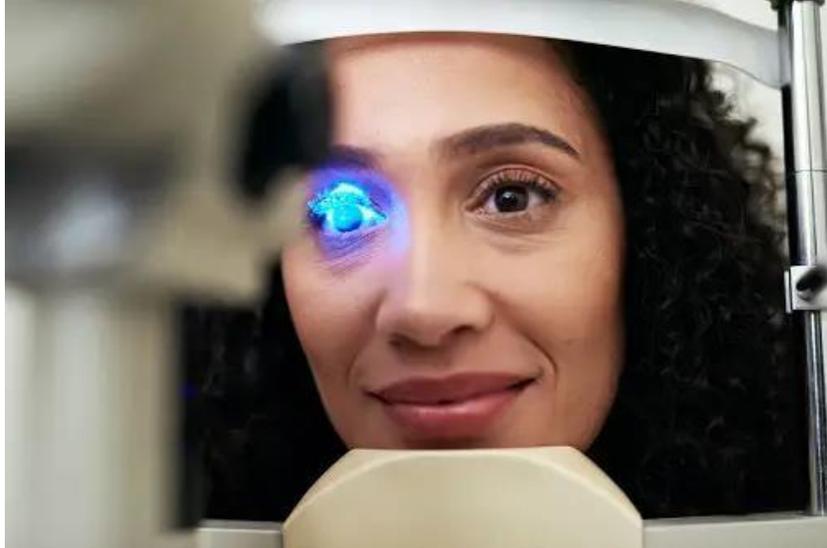
“I just thought I had a stye. The GP sent me to the eye hospital and they said it might be cancer. I have had 3 operations now and at the moment I am clear.”

The patient is central to why our service exists and central to the reasons we need to change. It is immoral to continue with the current level of care being delivered to the people of Wales. As part of understanding the needs of the people who require our care we have been working with third sector bodies to expand the breadth of NCSOphth. They have given us several situations where the current eyecare service has failed patients both from a delay to care causing harm, to a lack of holistic care for people living with vision loss. They have provided two reports with recommendations from the third sector to be considered integral to the transformation of eyecare that will come with the implementation of NCSOphth (appendix 1). Recommendations are aligned with The Eye Care Support Pathway (4) which is a framework that has been published by RNIB and partners to support the NHS, social care, third sector and the public to transform eye care services and was presented to UK government in the Westminster Eye Health day in December 2023. The report highlights the emotional impact of vision loss and the fundamental need to provide non-clinical support to people who are having to navigate sight loss or living with long term eye disease as well as the people who care for them. The clinical body in Wales consider the non-clinical support of our patients as a fundamental and essential part of transformation and should be integral to any changes to eyecare services.

Understanding Ophthalmic service delivery

Ophthalmology is unlike other secondary care and planned care specialties. These differences are an important part of what makes Ophthalmology unique, both in its challenges and opportunities. The misunderstanding of these differences and trying to manage services within an inappropriate template of other secondary care services has contributed to the challenges currently faced. It is also important to understand that services provided in secondary care eye services are distinct from services that can be provided in a primary care setting. Ophthalmology is unique as a secondary care speciality. Whilst it has a significant surgical aspect, non-surgical care is of equal importance and an equal proportion and demand on services. Surgical specialties generally have a non-surgical medical counterpart that cares for patients who do not need surgical intervention. For example, General Surgery who carry out abdominal surgery have a medical counterpart in Gastroenterology. In Ophthalmology the non-surgical outpatient workload is significant, with often lifelong care needed. This makes prioritising surgical activity over other aspects of the service inappropriate. Consultant care cannot be moved from their outpatient commitments to cover theatre as both aspects hold equal importance. Contributing to the perceived poor surgical productivity of fallow sessions. With the current workforce limitations, a move to prioritise surgical activity over outpatient activity will do nothing more than compound the current outpatient waiting list crisis and increase the risk to patient safety.

However, Ophthalmology cannot be considered in isolation from other secondary care services. Perception is often that ophthalmology is a “quality of life” specialty where mortality is not encountered. In reality, Ophthalmology has an integration with other services that contributes to significant healthcare outcomes. For example, Ophthalmology works alongside Neurology and neurosurgery to detect, monitor, and, via our orbital surgical team, treat brain tumours. Our Uveitis



service works with multiple different medical specialties to manage inflammatory conditions such as Sarcoidosis as well as Oncology to manage sight threatening complications of cancer therapy. Diabetic eye disease is often the first visible sign of end organ damage in Diabetes and input from Ophthalmic services allow diabetic teams to better manage patients care.

This is why secondary care services provided by Ophthalmology are essential and cannot be replaced by a non-medical workforce.

The eye is extremely complex and there are 9 recognised sub specialities within ophthalmology. Following the core Ophthalmology training (7 years of post-foundation doctor training, 14 years total) Consultant Ophthalmologists have undertaken even higher level training to allow them to be specialist in a particular subspecialty of Ophthalmology. These subspecialities are not interchangeable. For example, a medical retina consultant would not have the skills to manage a patient with complex glaucoma, and a Glaucoma consultant would not be able to manage a patient with complex diabetic eye disease. This means that patients may be under a range of different specialists within this single discipline and may need multiple open pathways of care, all just as important as the other.



Within Ophthalmology, imaging diagnostics are an integral part of the service. Ophthalmology care is heavily dependent on various methods of Ophthalmic imaging with most patients attending the service requiring additional diagnostic imaging, many needing more than one type at every visit. This means that diagnostic equipment, and the workforce to use, it are absolutely integral to the service and its functioning efficiency. In addition to the diagnostics, Ophthalmology services also include Emergency Eye care that runs as a separate service from the main hospital Emergency Department, dealing with all urgent and emergency cases both in hours and out of hours. Many other specialties can rely on other parts of the hospital system for diagnostic and emergency care but for Ophthalmology this is all part of the same service.

Currently waiting lists for HES are at all time high with an ever-growing demand and a fragility of workforce never previously seen. Serious incidents where patients have experienced irreversible sight loss due to service inefficiencies are growing and without a radical transformation this harm will continue. At present Wales has the lowest per head capita of Ophthalmology consultants of any of the 4 nations of the UK, almost 50% of the recommendation from the Royal College of Ophthalmologists, and in Europe only North Macedonia has fewer (5), whilst almost a third of the recorded planned care demand in Wales is for secondary eyecare services. Training across the workforce is variable and disjointed and estates are far from for purpose. In addition pathways of care are not always clear and consistent and delivery of services show marked variation across Wales. Failure of the current HES is multifactorial in nature and needs to be evaluated prior to solutions being formulated.

Strategy development

Welsh Government (WG), recognising that Ophthalmic services are an at-risk service, commissioned an independent report from an international expert on ophthalmic service design and delivery. The Pyott report was delivered in 2021 (6) and highlighted several issues within secondary care services that needed further investigation and investment to address the overwhelming issues being experienced. The report was always designed to provide a high-level overview of services to highlight areas of the greatest concern. Unfortunately, it transpired that much of secondary care Ophthalmic services in Wales failed to deliver the improvements required to meet the expected standards for a multitude of reasons that this national strategy looks to sustainably address, alongside the work of the National Clinical Implementation Network (CIN) for Ophthalmology.

Getting it Right First Time (GiRFT) (7) were commissioned in 2022 and undertook analysis in 2023 to deliver recommendations into two sub-speciality areas, Glaucoma and Cataract surgery. Again, significant issues in the ability to deliver these two specific sub-specialty areas effectively were highlighted. Many of the barriers highlighted were systemic in nature and required a wholesale transformational change in the way secondary care eye services are delivered across the whole of Wales.



Given the findings of these two high level reports, and the identification of Ophthalmology by the Strategic Programme for Planned care as an at-risk specialty, Welsh Government commissioned the development of the National Clinical Strategy for Ophthalmology (NCSOphth), delivered through the NHS Executive. This was following the success of the insights provided by the National Clinical Strategy for Orthopaedics published in 2022.

The aim of NCSOphth is to determine why the services are currently failing in Wales and set out a Blueprint for the sustainable future provision of Ophthalmology Services across Wales.

Methodology

In order to inform the blueprint for a sustainable future for Ophthalmology a number of methods were employed to determine the current points of failure and barriers to change that are contributing to the significant problems within secondary care Ophthalmology across Wales.

Clinical and Stakeholder engagement

Central to this strategy being clinical led was engagement with both the medical and the non-medical workforce across Wales. Three regional face to face workshops were held, South East, South West and North Wales. Consultant representatives from each health board with the exception of Powys, which has no standalone secondary care eye service. In the workshops consultants were asked through open discussion and a variety of exercises to identify the current service models across Wales, risks and barriers to change and to start to define what a clinically led service transformation would look like.

In addition to the Consultant workshops, five online interactive webinars were held which engaged stakeholders from all aspects of eye care delivery. There has also been one to one consultation with the NCSOphth leads and important partners including:

- patient facing non-medical clinicians
- administrative support staff
- health board operational leads
- primary care teams
- HEIW
- Third sector partners

Demand and Capacity analysis

The data analysis team in NHS Wales Executive worked with health boards to create an All-Wales clinical activity and demand data set. Along with the data team, the clinical leads created an data request for health boards to complete. Analysis was then undertaken on the returned data.

The data was interrogated to show waiting times for new patients, for all patients including follow ups and those waiting for treatments or interventions. It is important to note that this information is only collected for elective care. Emergency care via the on-call service or Emergency eye clinics do not contribute to this data set as it is only captured sporadically by Health Boards. Therefore, it is important to caveat this demand capacity data as being an underestimate of the actual work carried out by Ophthalmology across Wales.

Epidemiology projected demand for eye care services

Incidence and prevalence data for common eye conditions are widely available. Along with census data from Public Health Wales, a detailed mathematical analysis was carried out in conjunction with the School of Mathematics in Cardiff University to provide incidence and prevalence data for these conditions and projections for demand over the next 10 years.

Outcomes

Consultation

Engagement with the consultation process was largely positive and informative. All participants were able to discuss concerns and solutions in a protected open and supportive environment. It is important to ensure that all contributions from stakeholders are given the careful consideration they deserve as the frontline of HES. It is not unreasonable to say many of the consultant body have been heavily involved in attempts to reform services in the past and have grown disheartened and cynical by the lack of organisational commitment to effect change. It is important that this previous hard work is recognised and that we do not lose another generation of consultants to the disappointment of failure to deliver essential reform. Throughout the consultation process there were 3 main areas which were given as the most significant barriers to deliver of an effective HES. These were:

- Workforce
- Estates
- Digital solutions

Workforce

The Royal College of Ophthalmologists have guidelines around the numbers of substantive consultants per capita to run a successful service. This is 3.2 consultants per 100,000 population, with 3 being the minimum requirements. It is important to note that the consultant role is not limited to service delivery and this calculation is not based on numbers of patients that can be seen. This is a number that allows the consultant body to provide high quality clinical leadership and service development. This model works on an ideal of a consultant led service which is distinct from a consultant delivered service. The duties of a consultant extend beyond face to face clinical care and include training, service development, transformation and clinical leadership in areas such as governance. This is captured in the consultant contract for Wales, and it is this additional benefit from a substantive consultant that delivers an effective service.

With 65 substantive consultants, Wales has the lowest per head capita of consultant Ophthalmologists in the UK (1.8 per 100,000) and posts are often left unfilled. In addition, most HB do not have the establishment to meet the RCOphth recommendations. Furthermore posts cannot be recruited into and millions of pounds a year are spent on costly locum cover. For example ABUHB alone has a regular overspend of £70-80K a month to cover locum and agency costs to maintain services, with an average total cost of £1.7M a year. This leads to services which are overwhelmed by demand and limited by costs, where consultants are acting as firefighters to address immediate needs and targets rather than having the capacity to build sustainable delivery models or design and deliver radical reform as seen in PCES. This in turn leads to burnout and more consultants leaving the NHS for less stressful working environments. The reasons around the significant shortage of consultant workforce in Wales was thought to be multifactorial. Changes in recent years to trainee recruitment processes, moving from a deanery based to national recruitment process has been perceived to

The workforce survey carried out by RCOphth in 2022 (8) showed that 65% of respondents planned

increase the request for ophthalmology trainee transfer out of Wales training placements made on a UK wide basis often lead to trainees being placed in areas of the UK they do not want to work in. Whilst RCOphth support Wales in looking to move to a local recruitment process it is not yet clear how this could be facilitated.

Furthermore, RCOphth have recognised this crippling skills shortage and have recommended that a further 36 trainees over 7 years are allocated training places in Wales. However, again, how this can be implemented in the current environment is unclear. It requires support from H E I W , funding from Welsh Government for additional training places through NWSSP and support from HB to commit to an increase in establishments of substantive consultant posts. Given the current shortage it is unclear how this additional training support needed within the service model can be delivered.

These recruitment challenges extend to other ophthalmic staffing groups, with many sites report key vacancies in the administrative and support functions that are vital to the running of an effective service. All Health Boards have reviewed or are in the process of reviewing their staffing structures and are required to adopt a 'grow your own' approach because of the skills shortage in this specialty. The issues are felt most acutely in rural parts of Wales and particularly in the west, both North and South of the country.

Given the complexities around the problems faced by workforce and training this will form the basis of a stand alone supplemental report.

Estates

It was widely recognised within the stakeholder consultation that maximum service efficiency and future service expansion is blocked by lack of space and the state of repair of estates.

Contract reforms in PCES was warmly welcomed but in order to provide training for optometrists to deliver the extended roles, all Health Boards are struggling to find the physical space to allow them to complete the training requirements and so will limit the potential of WGOS reforms.

Commendable investment has been made in projects for Swansea and temporary hired theatre space for Cardiff, but across Wales most units have insufficient space to provide the core service. Historically, ophthalmology served a smaller number of ambulant patients, surgical treatments were limited, and the

specialty estate was allocated accordingly, often split across sites with poor access.

Every ophthalmology unit in Wales has now outgrown their space. Diagnostics require equipment and space. Cataract demand and sub-specialty surgery for previously inoperable conditions such as glaucoma and corneal grafts need specialist theatres. A sustainable future of ophthalmology in Wales needs space, not just to deliver core but to get better. There was overwhelming consensus that workforce needs to expand however with current space limitations this remains a challenge. This is true of all training needed

Since 2017, Ophthalmology is largest outpatient patient specialty in the NHS and performs the highest number of surgical interventions by some margin. However, the historic perception of HES being a "small service" persists.

within eyecare to address the dire workforce shortages and to allow transformational change away from consultant delivered to a more effective and efficient consultant led model of care delivered within a coherent multi-disciplinary service and across a fully integrated eye care pathway. Co-location of services and administration is essential for optimal efficiency.

Aside from the physical space limitations, existing provision in many areas is not fit for purpose. 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.

Ophthalmology requires technology for diagnosis and treatment. All health boards have some proportion of outdated or obsolete equipment, much of which is over 20 years old and needs replacing. Inconsistencies in equipment procurement across Health Boards has meant that some units have the bare minimum required to provide an effective ophthalmic service. When essential equipment fails, some units are required to resubmit bids for replacement. Patients lose sight waiting for their procedure. No Health boards have any kind of capital replacement plan for equipment. Removing barriers to replacement procurement would stabilise the service and reduce patient risk.

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Digital solution

There was consensus across all stakeholders that the lack of a digital solution across eyecare in Wales is limiting potential for reform within both HES and PCES. In 2017 a report from Health Inspectorate Wales highlighted potential harm from the lack of an electronic referral system from PCES into HES and mandated this be addressed. This expanded into the procurement of an all Wales electronic patient record to be used in PCES and HES to allow seamless transfer of data between the services and allow the potential for a fully integrated eye care service to be realised in Wales far ahead of the rest of the UK. To date the use of electronic referral systems or electronic patient records across Wales are patchy at best and no unit in Wales has a fully functioning EPR used across all services.

Reliance on paper records in Ophthalmology is an outdated practice, has significant risks associated

with it, and severely reduces the ability to transform services in ways that have been successful in other areas of the UK. NHS Scotland is progressing rapidly with roll out of EPR across HES and PCES to provide integrated care. In addition to providing transformation service change and data sharing across an integrated eye care pathway an EPR and referral system allows accurate and up to date auditing of activity and services at the push of a button.

In addition to considerable frustration around the lack of EPR and referral systems it was widely acknowledged that a complete digital strategy for eye care needs to be developed to ensure services are optimised. Ophthalmology is extremely data heavy. Digital images, often multiple modalities are captured on approximately 80% of patients attending secondary care services. Many primary care practices also have high quality imaging capabilities. There needs to be a way of protecting this data need in addition to allowing image sharing across HB boundaries and PCES and HES. Without this capability seamless pathways of care cannot be formed.

There is limited integration of all digital solutions within the NHS in Wales with much of the technology reaching the end of its useful digital life and requires considerable investment to bring services up to date. This is not a problem unique to eyecare but it is important to consider the integration of bespoke eye care packages when designing new generic digital solutions. No HB has a dedicated informatics or data support specific for Ophthalmology despite our extremely data heavy service.

Lack of an effective digital solution for eye care in Wales continues to limit the transformation of services and the potential of WGOS reforms.

Demand and Capacity

At its best, national data allows us to appreciate the enormity of the service needs, however, planning on a HB or regional basis with certainty or clarity of accurate subspecialty demands, or to plan standardisation of services across Wales is not possible.

Demand and capacity requests were made of each Health Board regarding Ophthalmic services. Responses were extremely variable with no data being provided by 2 of the 7 HB despite repeated requests. Data collected around demand and capacity of Ophthalmic services had marked differences between HB. There was no consistency in the granularity of the data with some providing total number and other having some limited subspecialty information. No HB could provide accurate capacity data with marked variation in coding, clinic templates and utilisation. There was marked differences

in pathways between and sometimes within HB. The extreme difficulties with data extraction and analysis have led to marked delays in being able to evidence service need across Wales and has delayed the delivery of NCSOphth. We are still yet to have data with enough granularity to fully understand the complexities of the HES. This demonstrates a significant finding and failure of current ways of working.

Further analysis of HB data is needed and development of standardised reporting and coding across Wales is essential. Ongoing work in this area will be carried out through the implementation of NCSOphth, however the task is far greater than first anticipated.

Eyecare measures and Patients Waiting

Unlike other specialities Ophthalmology has a national risk stratification, or health risk factor (HRF) in place to prioritise those at the greatest risk of irreversible harm

- R1 - Patients may suffer serious irreversible harm from delays
- R2 - Patients who may suffer reversible harm from delayed appointments
- R3 - Patients who may be inconvenienced or suffer mild/reversible consequences from delayed appointments

This was put in place to ensure that those in greatest need were seen first and HB are accountable for reporting within these HRF. This was an important step in ensuring care is delivered to appropriate need, however over time there are areas where this framework could be improved upon have become evident. Data in figure 1 below demonstrates that the majority of patients waiting for care fall within R1. However there is little distinction made between R1 patients at risk of rapid sight loss or those who need slightly less frequent review.

Volumes by Month and HRF

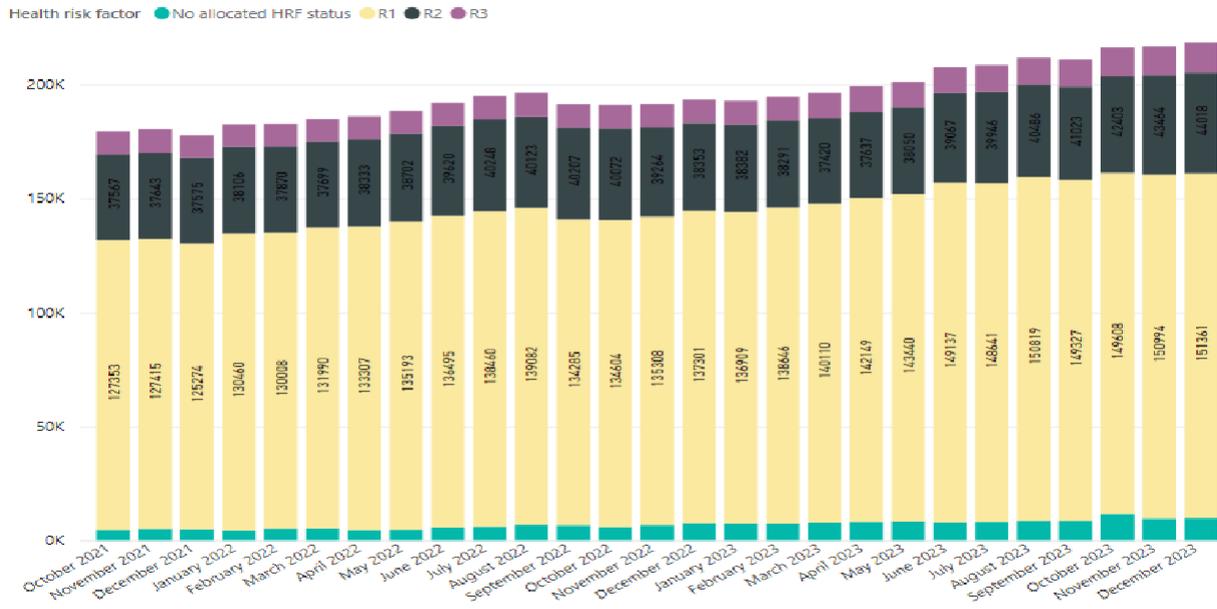


Figure 1: patient volumes by month, by Health Risk Factor (HRF)

Figure 1 shows that the numbers of patients under the care of Ophthalmology services has been steadily rising from 180,000 in September 2022 to **over 210,000 people on waiting lists for Ophthalmology** in December 2023. Critically over 150,000 of the patients re categorised as Health Risk Factor 1, defined as “risk of irreversible harm or significant patient adverse outcome if target date is missed”.

New Patients and referral rates

New demand for Ophthalmology services is demonstrated through new outpatient referrals (Figure 2). **Referral rates are up by 17% on pre- pandemic levels.** This overlies the pre-existing problems with capacity leading to an ever-increasing service demand. More work is needed to understand the detail of this increasing demand and how it can be addressed by WGOS reforms.

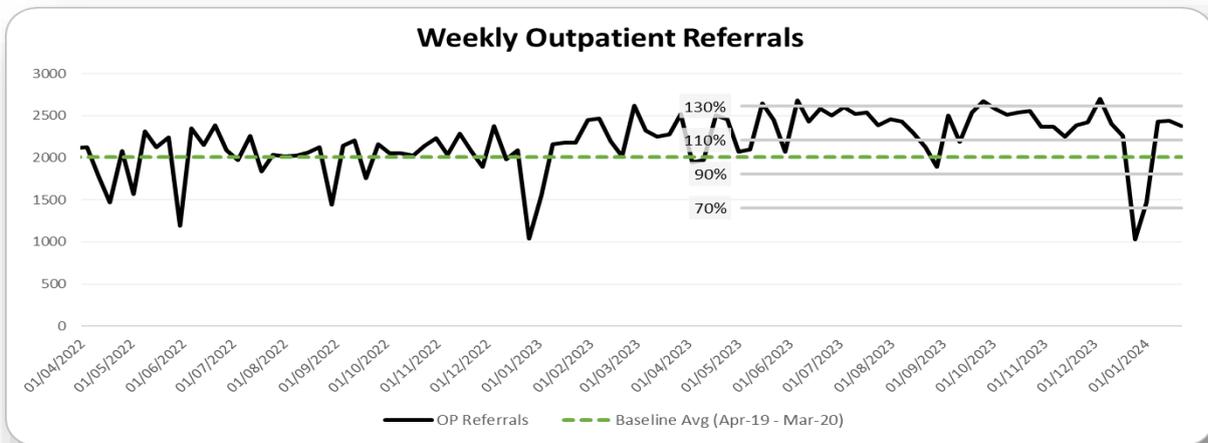
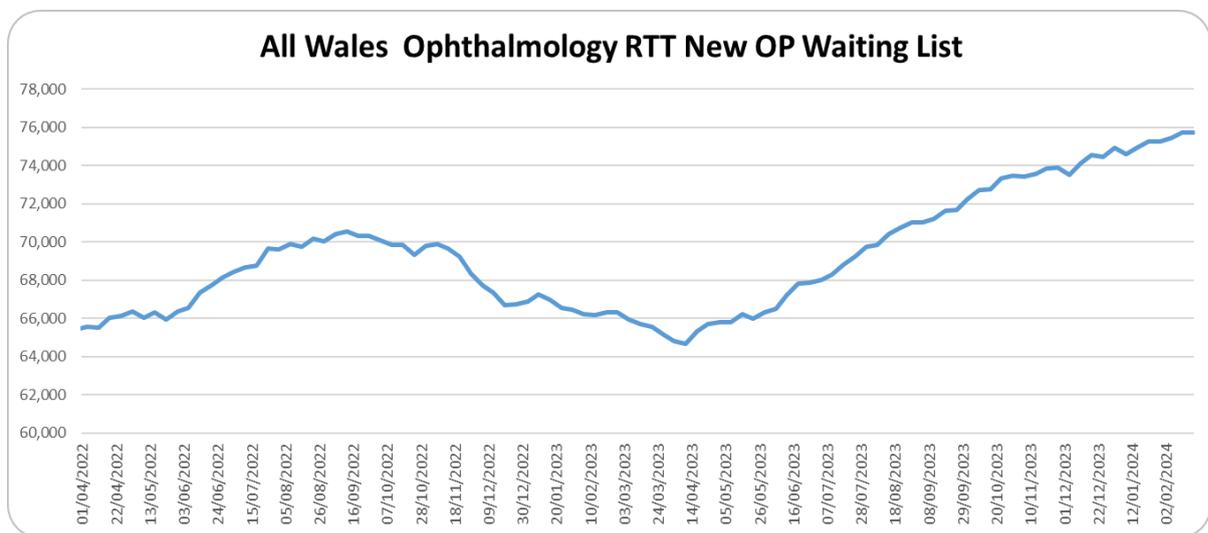


Figure 2: All Wales weekly referral numbers demonstrating increase in referrals to secondary care.

There are currently 76,000 are waiting for a first out patient appointment. These patients do not currently have a confirmed diagnosis and are unlikely to be receiving adequate treatment.



Long waiting patients and Harm

Figure 3 shows the numbers of long waiters across Wales, defined as those waiting over 104 weeks.



Figure 3: patients waiting over 104 weeks

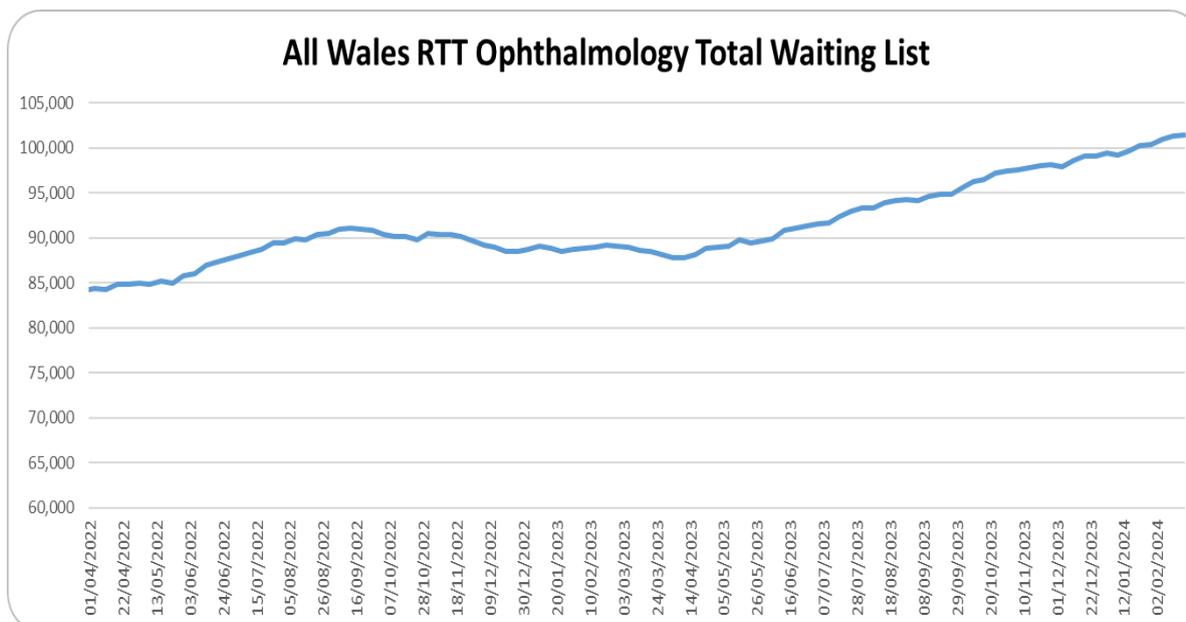
Post pandemic showed record levels of patients waiting over 104 weeks peaking in March 2022, at just under 10,000. This saw a rapid decline with the introduction of recovery funding and initiatives to just over 2000 although never reached pre-pandemic levels. With the reduction in access to the recovery initiatives numbers waiting over 104 weeks has steadily risen again to just over 4000 in February 2024. This is due to a number of complex factors including increasing referral rates and late presentation of cases requiring urgent care. For example an HCRW RfPPB funded project in Swansea University is currently looking at the negative impact of routine care of patients with diabetes halting during the pandemic. This includes Diabetic eye Screening, and its impact on more advanced presentation of disease to secondary care services.

Follow-up care

Attention is often focused on new patient appointment times however Ophthalmology has a significant follow-up burden. Many eye conditions require lifelong care than requires regular follow-up review to reduce the risk of permanent vision loss. Whilst the introduction of the WGOS 4 monitoring pathways for Glaucoma and Medical retina will help support some of the follow-up demand there will still be a majority of patients that need ongoing care in HES. The target for review is set by the responsible clinician and outcomes are measured at how close to this time patients are reviewed.

Of the 210,000 patients waiting only 40% are seen within target time. Another 40% of patients are waiting over 100% of their target time.

There is no measure of how far over 100% these patients are waiting



Unscheduled care

Given the specialist nature of eyecare, emergency or unscheduled care is provided entirely within HES. There is a significant workload associated with this aspect of HES however no HB could provide reliable data on the numbers seen within this part of the services. An estimation can be made given the numbers seen in the Eye casualty departments, of approximately 675 patients per week. This doesn't include those seen as out of hours on call service or who may be under shared care due to complex presenting conditions such as multiple trauma or those requiring multi-team input. Currently in Wales there are only 2 Emergency eye care consultants in post, BCUHB central and SBUHB. Most units cannot provide a fully staffed out of hours service, at all levels, and rely on locum cover to plug gaps. Demand data regarding unplanned care is difficult to obtain as on-call doctors often work alone in varied environments without support staff impeding data registration

Whilst it is hoped that introduction of WGOS 5 and the use of PCES to manage the lower risk unscheduled and urgent care problems will reduce some of the pressure, Emergency eye care departments are an essential service. We have already seen some improvement in numbers attending due to the introduction of WGOS 5, however limited space and trainers in HES needed for optometrists to gain the qualification to provide the service are currently limiting the number of independent prescribers in the community and so limiting the maximisation of this service.

On-call work often produces emergency or urgent surgical intervention. As discussed previously Ophthalmology is an extremely specialist service and requires a very specialist surgical environment in which to operate. Everything from the trolley the patient lies on, to the chair the surgeon uses is specific to Ophthalmology. Surgical scrub teams are not interchangeable and surgeries usually require a specialist Ophthalmic microscopes, often ceiling mounted and not mobile. For this reason the emergency on-call work has to happen in dedicated Ophthalmic theatres with specialist Ophthalmic support teams. Therefore, this unfortunately necessitates the cancellation of elective surgical care. Much research has shown that outcomes are significantly improved by the use of specialist theatres and not undertaking emergency ophthalmic surgery in a general out of hours or overnight environment. However, it is important that adequate specialist support is given over weekends and bank holidays but this is not the case in many units.

Epidemiological analysis

The ageing population projections for Wales over the next two decades (Fig. 4) will result in increased prevalence of age-related ophthalmic diseases. Current lack of UK population-based surveys, confounded by poor referral and diagnosis data coding, causes difficulties for service planning. This necessitates epidemiological modelling to predict future demand and aid in planning for capacity shortfalls in an already strained service.

Between 2023 - 2033, the number of those aged over 80 years is projected to increase by 16.0% 31.3% , by 2043 this will be a 56% increase.

Approximately 60% of the patients seen in Ophthalmology present with the three most common conditions of Cataracts, Glaucoma and Retinal Diseases. Reviewing the projected increase in demand for these three sub-specialties with larger patient numbers enables an understanding of the demand projections across all Ophthalmology services.

Ageing Population

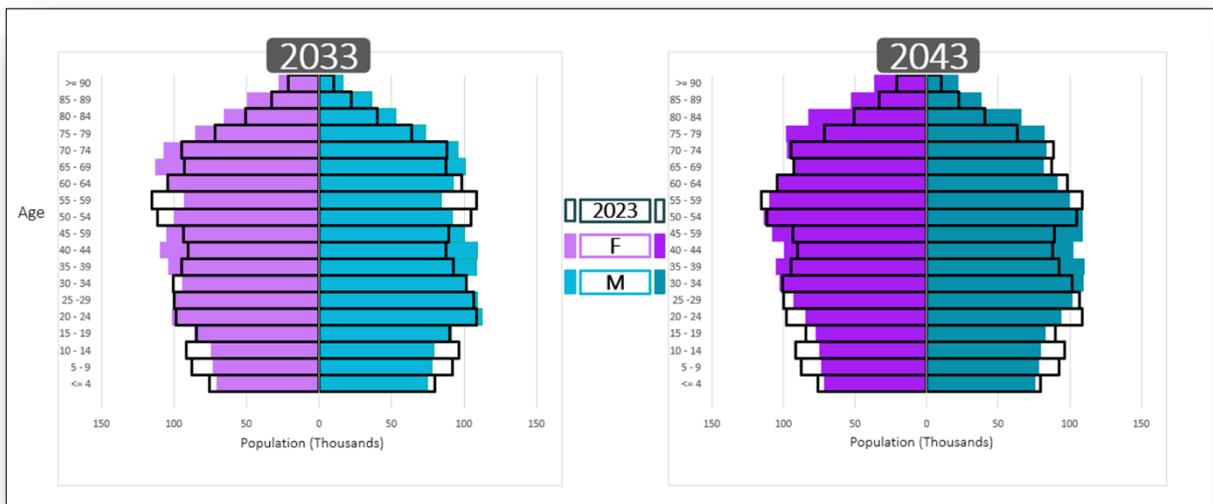


Figure 4 Between 2023 - 2033, the number of those aged ≥ 70 and aged ≥ 80 years is projected to increase by 16.0% (505 to 586K) and 31.3% (182 to 239K) respectively. With further projected increase from 2023 - 2043, the number of those aged ≥ 70 and aged ≥ 80 years is projected to increase by 32.7% (505 to 670K) and 56.0% (182 to 284K) respectively.

Definitions are important to understand the research data and what it means for the future demand for Ophthalmology Services. The **incidence** of a condition is the number of new cases per year and the **prevalence** is the number of people within the population have the conditions at any given time.

Over the next 9 years to 2033 the incidence and prevalence are expected to increase by:

- Cataracts incidence increase by 11% (fig. 5), prevalence increase by 12.5%
- Glaucoma incidence increase by 11.7%, prevalence increase by 13% (fig. 6)
- Retinal Diseases incidence increase by 13%, prevalence increase by 12.6% (fig 7)

Cataracts demand is set to increase by 11% over the next 9 years to 2033. This projection is based on the GIRFT report national mean conversion rate for cataract surgery of 71%, which is the percentage of referred patients that proceed to have cataract surgery. Current total capacity for cataract surgery provision in Wales is estimated to be approximately 25,000 cases per year, highlighting the drastic shortfall in current capacity compared to the increasing demand, resulting in ever greater waiting lists.

Glaucoma **prevalence is expected to increase by 13%** from **88,700 to 100,130** over the next 9 years to 2033. As Glaucoma is an outpatient led, follow up subspecialty the prevalence data is critical as it shows the full demand for the service as each patient suffering with the condition will require attention and monitoring of disease. Whilst low risk glaucoma patients can be monitored under WGOS4 complex care and surgical intervention will still be required in HES and cannot be underestimated.

The major retinal diseases, age related macular degeneration (AMD) and diabetic retinopathy are also set to show a 13% increase. These services are out patient based and incorporates intravitreal injections that are required at specific time intervals, deviation from which can cause deterioration in sight.

This data shows that demand is projected to increase at an alarming rate over the next ten years. Continuing at the current trajectory, without urgent action, will result in an unsustainable model of eye care provision in Wales

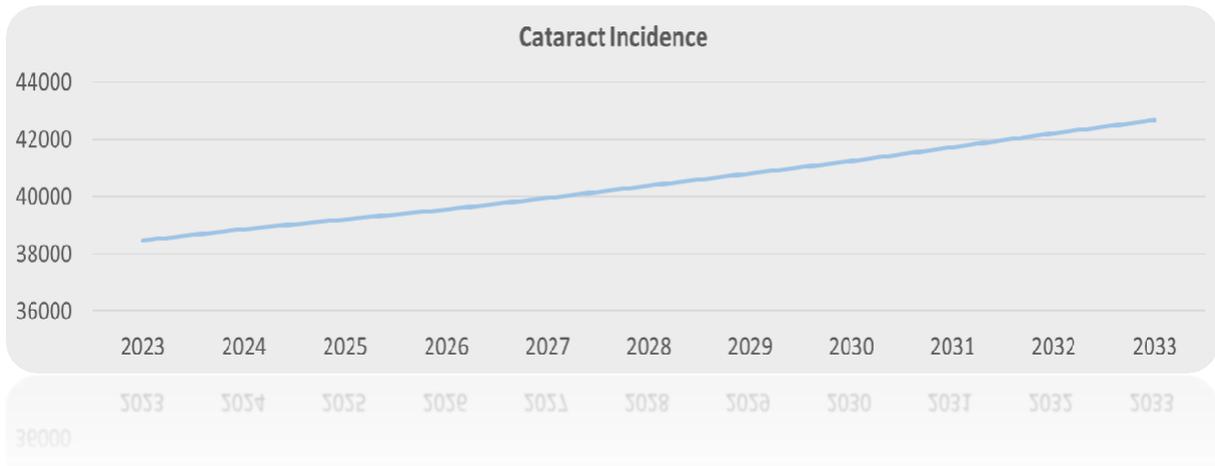


Figure 5: Cataracts incidence (or demand) increasing by 11% over the next 9 years to 2033. This projection is based on the GIRFT report national mean conversion rate for cataract surgery of 71%, which is the percentage of referred patients that proceed to have cataract surgery. Current total capacity for cataract surgery provision in Wales is estimated to be approximately 25,000 cases per year, highlighting the drastic shortfall in current capacity compared to the increasing demand, with resultant future exponentially greater waiting lists.

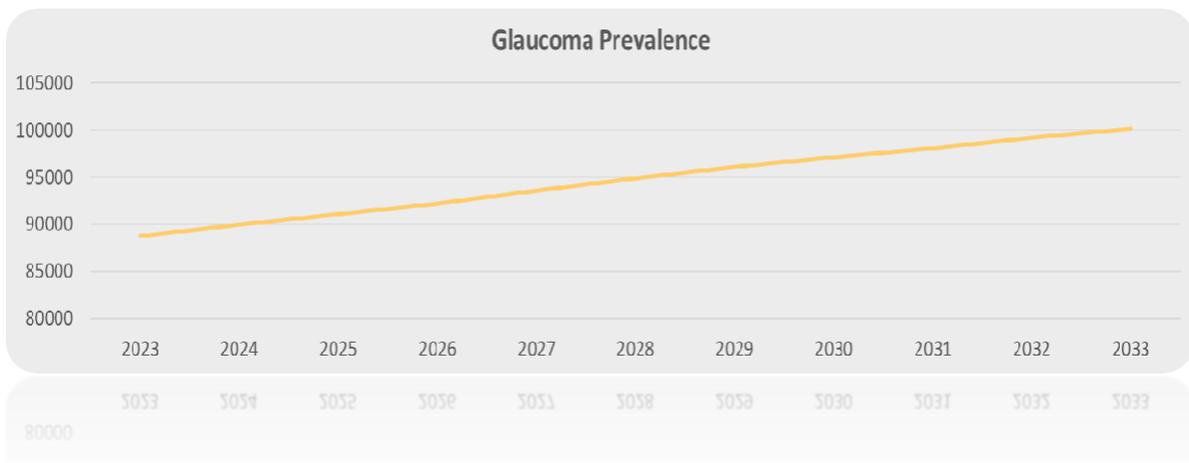


Figure 6: Glaucoma prevalence increasing by 13% from 88,700 to 100,130 over the next 9 years to 2033. Glaucoma incidence (or new demand) increasing by 11.7% over the next 9 years to 2033. As Glaucoma is an outpatient led, follow up subspecialty the prevalence data is critical as it shows the full demand for the service as each patient suffering with the condition will require attention and monitoring of disease.

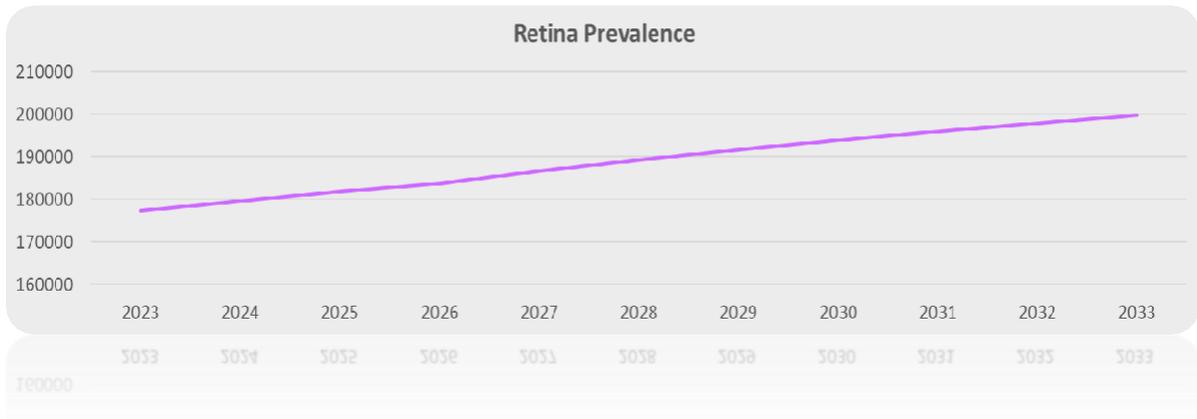
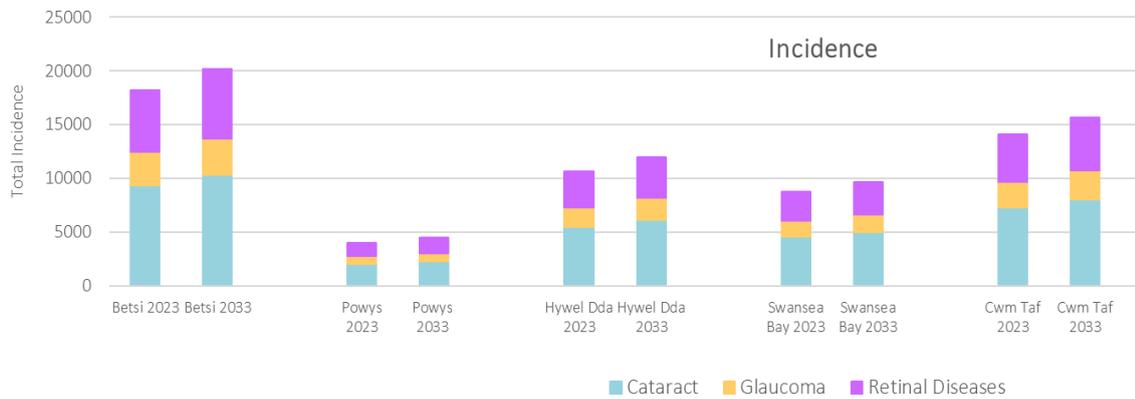
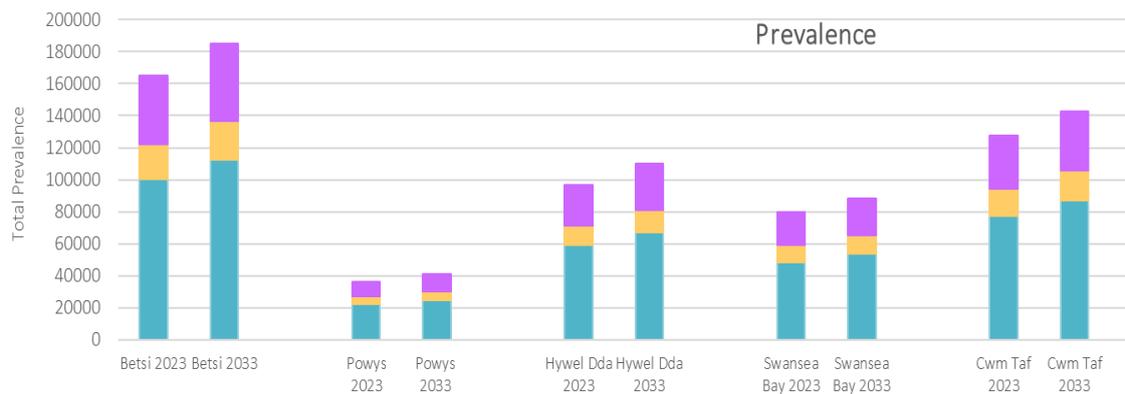


Figure 7: Yearly increase in retinal disease prevalence. The projection includes the major retinal diseases, age related macular degeneration (AMD) and diabetic retinopathy. Medical retina is an outpatient specialty that is under significant strain already, which also incorporates intravitreal injections that are required at specific time intervals, deviation from which can cause deterioration in sight. Intravitreal injections are sight saving.

Incidence data by Health Board (numbers of new cases per year)



Prevalence data by health board (total number of people with the condition)



The Solution:

National Clinical Strategy for Ophthalmology

The National Clinical Strategy for Ophthalmology is the proposed way forward for Ophthalmology Services in Wales. It provides a strategic framework to shape the clinical and support service to ensure a sustainable service in the future. Given the unexpected difficulties in extracting and analysing granular specialty and Health Board data the delivery of NCSOphth will be in a phased manner. This report will give the strategic overlay of the blueprint for change whilst there will be a number of subsequent reports tackling the more detailed aspects of service transformation.



Strategic themes

The background work has allowed us to develop a plan which has four overarching strategic themes that will allow us to shape the delivery of Ophthalmic services. This will allow us to build a sustainable service which allows us to provide excellence in eyecare across a fully integrated pathway and retain eyecare services within the NHS in Wales, providing the best value care for our patients and ensuring



those with the most complex needs will not be disadvantaged.

Organisational Reform

Maximising our culture and workforce to best care for our patients

By

addressing the fundamental problems within the structure we currently work in, we can move towards organisational transformation that will ensure Ophthalmology in Wales has a culture of inclusivity and progression with a future thinking approach to patient care.

Organisational Principles

- 1. Ophthalmology will be prioritised within the provision of planned care and standing commitments made to improvement in services should be honoured.**
- 2. There will be commitment to the delivery of Ophthalmic services on a regional basis**
- 3. Health Boards will align governance finance and priorities to a regional delivery model**
- 4. There will be executive level support for regional services and the delivery of regional services will be protected**
- 5. Health Board organisational development teams will work with operational and delivery teams, including clinical staff, to align to a regional model of care**

Health board commitment to Eyecare Services

Health boards are responsible for provision of eyecare services, both HES and PCES. As there are limited mortality measures associated with eyecare, services are often overlooked in favour of others. This lack of commitment and prioritising of eyecare services can lead to disengagement of clinical bodies and patients coming to harm. The commitment showed to primary care contract reform needs to be mirrored by Health Board into HES. This involves the use of Eye care collaborative groups with stakeholders from all aspects of eye care with an Executive lead to direct service development across the entire pathway. Within secondary care, Health Board programme and delivery groups will ensure that plans for any transformation within HES are given equal standing to other services and are not

overlooked. Any plans passed as executive level should be prioritised and should not be derailed by archaic ways of coal face working.

Regional reforms

Regionalisation of HES are fundamental to the future of Ophthalmology. There are different aspects to regionalisation of services and each needs to be considered by the regions of Wales as they progress their regional Ophthalmology work. Whilst there are small aspects of regional working underway in Wales there needs to be wholesale overhaul of the behaviour of health board as individual organisations before consideration of implementation of clinical service transformation. Without underlying governance and infrastructure in place any clinical pathways will remain fragile and ineffective. This has been demonstrated with the challenge of implementation of regional cataracts services in South East Wales which as met considerable challenges with having to navigate governance and finance of 3 different health boards to provide services. Therefore the following recommendations are made:

1. *Quality and Safety*

Each region needs to identify the current delivery of services and where the greatest areas of risk regarding the quality and safety of services lie. This may not be the highest volume services such as cataracts but may be the more sub-specialist care that has the most marked fragility of workforce and the greatest risk for patient harm. Each Health Board in the region needs to agree on a regional strategy for addressing these risks.

2. *Service sustainability*

In order to be sustainable the service needs to agree a regional ophthalmology budget which is ringfenced and pooled with a central finance governance not dependant on individual Health Board constraints. Where there are multiple HB operating within the region consideration should be given to solutions to address these issues such as requests for the establishment of statutory regional organisations, and single employer approaches.

Workforce needs to be reviewed and aligned to a regional model of care. Organisational development departments will be central to this move in culture for often siloed workforces. There needs to be cultural shift at all levels to thinking of Ophthalmology as a regional service and it needs to be integral to all future service delivery. There needs to be a review of job planning and employment to ensure consistency across the region to allow interchangeable consultant level workforce across the region and services to be delivered on appropriate site. Non-medical workforce and operational workforce need to have alignment of job descriptions to allow a mobile workforce to address needs on a regional rather than Health Board basis. Clinical leadership is essential; proper time and consideration must be given ensure the highest clinical standards are met.

3. *Delivery*

Delivery of regional services need to work from a centre where complex and specialist services are delivered. This will be the highest level of skilled care provided by tertiary teams for each of the sub-specialties within Ophthalmology. There needs to be a network of more local units which can deliver less complex care closer to home, this may include high volume low complexity hubs to provide cataract services. along with diagnostic and treatment hub within the community supported by the extensive primary care eye services

Workforce principles

- 1. A cross professional workforce plan will be developed to address current gaps and future projections. Succession planning is critical.**
- 2. Fully job planned multidisciplinary and multi professional teams with formal recognition of clinical and service development roles will exist within every unit in Wales.**
- 3. The importance of training will be recognised with dedicated time to provide high quality training for all members of the wider Ophthalmology team. Training will be protected and prioritised.**
- 4. Non-medical clinicians will work to a standardised competency framework across Wales for shared roles.**
- 5. Hospital optometry departments will be developed in every unit to support HES and integration of primary care optometrists in sessional roles.**

Medical workforce

The Clinical Implementation Network (CIN) will work with clinical leads and Health Boards to ensure consistent job planning of current consultants. There is variation across job planning rules across Health Boards and this needs to be addressed as part of a wider sustainable approach outside of the scope of NCSOphth. Training of Ophthalmic trainees must continue to be the priority of the consultant body along with the introduction of formal Ophthalmic Local Training (OLT) with particular emphasis in locations traditionally difficult to recruit into. Doctors of all levels will commit to the training and support of non-medical workforce, but this cannot be to the detriment of the medical training experience. Very strict guidance exists from the GMC and RCOphth on training medical workforce and if these are not met training grade doctors can be removed from units. The investment from Welsh Government in a state of the art simulation suite in Cardiff University demonstrates that commitment can be made and should be of a recurrent nature.

According to RCOphth workforce survey, 65% of respondents in Wales planned on leaving the workforce in the next 5 years. Many of these will be a planned retirement. It is paramount that units work to identify upcoming changes at the earliest opportunity and work on a regional basis to ensure units are not left with large medical workforce gaps. Health Boards must work collaboratively with

each other and with the Ophthalmology teams to advertise posts in a timely manner to maximise potential recruits.

Without these changes HES in Wales will continue to be dependent on locum posts which do not provide a sustainable approach or investment on transformation of service delivery. In turn the medical workforce will commit to change and new ways of working to meet demands as well as giving a commitment to maximise productivity.

Non medical clinical workforce

Across Wales there is a marked variation in the way the non-medical workforce works in HES. By creating a multi-professional sub-group of the CIN we will work to ensure that the non-medical workforce work to a competency based framework to deliver care. A future workforce will maximise the Multi Professional approach, sharing skills and experiences to maximise patient care. An agreed Wales wide best practice model for optimum MDT working will be developed and implemented. All clinical staff will work to top of their registration and non-registered practitioners enabled to take on roles as recommended by the RCOphth and GIRFT.

Operational workforce

The operational team, and particularly those who hold administrative roles are often overlooked in terms of delivery of care. High quality care can only be delivered where there are close working relationships with the non-clinical members of the team. Co-location of service enhances this relationship and provides a more cohesive working environment and contributes to a more effective way of working.

Case Study

Creative ways of maximising the workforce and enabling practitioners to work at the top of their licence have been introduced within Swansea Bay University Health Board. A multi-professional approach has been implemented that blends the skills and abilities of Orthoptists, Hospital Optometrists, and the registered and non-registered nursing professions. Considering functions rather than traditional roles has modernised the workforce structures and created additional training and development opportunities for the non-medical staff that has also increased morale and retention in the service.

Clinical Networks

All Wales Clinical Networks to deliver the highest quality evidenced based care and ensure equity across the Nation

Welsh Ophthalmology has a history of engaged clinicians striving to make service and system changes for the benefit of patients. By building on this and expanding networks across the integrated pathway and to include non-medical clinicians we can ensure equality of care and equity of access for all patients in Wales.

Clinical reference groups

1. **Develop clinical reference groups for each sub-speciality within Ophthalmology**
2. **Strengthen links across PCES and HES**
3. **Agree nationally on best practice and undertake benchmarking**
4. **Ensure practice is evidence based and clinically led**

Clinical reference groups

Ophthalmology has nine distinct subspecialty areas:

- Medical Retina and Uveitis
- Glaucoma
- Oculoplastics
- Paediatric Ophthalmology
- Cornea
- Cataract
- Emergency Eye care
- Neuro-Ophthalmology and Adult motility
- Vitreo-Retinal services

Within each of these there are distinct evidence examples of best practice. The Clinical Reference Groups (CRG) will review the evidence base and develop all Wales pathways of care, Welsh National Clinical guidelines and steer the work of the CIN in specific sub-specialty areas.

Specific details around sub-specialty working was expected to be part of the initial NCSOphth delivery however, considerable barriers around coding and data collection within Health Boards has meant that this has not been possible. The CRG's will be able to understand the granularity of requirements for delivering a high quality and effective clinically led service. By agreeing a national approach to the most common aspects of sub-specialty care we can ensure that patients across Wales are getting equal quality of care whilst ensuring that a this is being delivered in the most cost-effective manner without compromising standards.

The clinical reference groups will also act as subject matter experts in the ongoing integration of primary and secondary eye care. By building close working partnerships with Optometric colleagues, including the WGOS National Clinical leads the CRG's can ensure that the high standards expected from secondary care services are translated into the expansion of enhanced optometric services in primary care.

Case study

During the development of the Wales General Ophthalmic Services (WGOS) pathways that underpin the Optometric contract reform WGOS National Clinical Lead have worked closely with medical retina and glaucoma Clinical Reference Groups. This has contributed to the development of the WGOS handbooks and minimal data sets expected for WGOS 4 to be delivered in the community. This has ensured that the same exacting standards expected when patients attend Hospital Eye Services are translated into Primary Care Eye Services and there is no disadvantage for patients being seen via WGOS pathways.

MDT working

- 1. Empower non-medical clinicians to achieve their potential**
- 2. Standardise training and competency recognition across Wales above local constraints**
- 3. Enhance and promote the multi-professional team throughout the Hospital Eye Services (HES)**
- 4. Explore novel and innovative approaches to delivering care outside of the traditional consultant delivered model of care**

There is simply not enough ophthalmic medical workforce to meet the demand in Wales. Whilst strategies will be undertaken to address this shortfall, the worst in the UK, the opportunities for multiprofessional working cannot be underestimated. Within HES there are a number of non-medical clinicians that have traditionally been part of the workforce. This includes nursing, optometry, orthoptics, ophthalmic technicians and imaging services. In a traditional model of care these would provide support to a consultant delivered service which draws of core competencies of individual professions.

This is an extremely inefficient way of working. It limits not only the number of patients that can be seen within a service but also limits the potential of the workforce. There are a number of established enhanced roles within HES in Wales such as the use of non-medical injectors for macular degeneration services but the provision of more innovative use of skills is patchy and often limited by local governance constraints that are not always pertinent to ophthalmic services.

By accessing training and support many non-medical clinicians could be skilled to undertake a significant proportion of the service deliver in HES and move the service away from a traditional consultant delivered model of care to one that is consultant led. By standardising training, ensuring equity of access across Wales, and moving towards true competency and skills-based working rather than labelled professional constraints.

Developing an all Wales Multi-Disciplinary Team Clinical Reference Group will allow us to move towards this goal.

Patient engagement and third sector partners

1. **Centralise care to patient need and expectations**
2. **Work with third sector partners across Wales to ensure NCSOphth maintains the patient at the heart of transformational change**
3. **Work with PECS to ensure that patients moving into community- based care are not disadvantaged**

When looking at the enormity of healthcare provision, the patient and their needs can be overlooked. When faced with huge numbers on pages and ever growing graphs it is sometimes easy to forget that each of those numbers is a person and their care is on our hands. The patients who access eyecare can have very specific accessibility needs that cannot be ignored. Vision impairment can limit independence and the use of drops that blur vision in examinations mean that patients cannot drive themselves to appointments and so are dependent on other means of transport. Moving care from HES to PCES can also raise concern in patients. Furthermore, established vision support services within secondary care currently have a limited presence in PCES.

It is therefore vital that patient groups are key to each of the clinical networks that are developed to provide information about the patient needs and priorities. This is a collaborative approach and the close working partnership will also help patients to understand planned transformation of services and the potential need for them to access services differently. More information can be found in Appendix 4

Pathway Transformation

Ensuring pathways across the entirety of the patient journey provide seamless integrated care delivered to nationally agreed standards

The implementation of pathways across eyecare will ensure that patients receive equality of care across Wales. There are multiple resources to allow seamless delivery of care across the whole integrated eye care pathway. This will ensure that no matter where a patient is in Wales they can expect the same standard of care and support.

Secondary care pathways

- 1. Recognised UK guidelines including GIRFT and RCOphth will be adapted to delivery in a Welsh healthcare system.**
- 2. Standardised pathways will be expected to be implemented across Wales to deliver expected best practice and efficient care**
- 3. Implementation of clinically agreed pathways will make data collection, analysis and comparison more accurate to allow for planning of services.**

There are several UK recognised recommended pathways including those provided by Getting It Right First Time (GIRFT) and RCOphth. These are generally developed for use within NHS England and will require review and adaptation to NHS Wales. Furthermore, it is important to understand that the delivery of efficient pathways relies on well-functioning infrastructure and implementation of pathways is unlikely to be successful without the organisation reform discussed previously. Each of the Clinical Reference Groups will develop sub-specialty specific pathways that will be agreed nationally and implemented regionally.

Cataract services

Delivery of cataract services in Wales is an example of how lack of efficient pathways coupled with operational challenges have led to an all-time high waiting list for care. Efficient cataract services as outlined by GIRFT rely wholly on pathway design and implementation. Whilst there is an element of

adaptation by the medical workforce to high volume working, without clear pathways in place a high-volume service can never be achieved. The patient journey begins when referred from primary care. A robust pathway from the outset will ensure the patient is seen in a single pre-operative visit by an appropriate clinician where all paperwork needed including patient consent and lens choice is made. Admission for surgery is within 6 weeks to limit potential adjustment to surgical needs. On admission all paperwork is present and admission protocols are in place and followed allowing the surgeon to proceed with limited adjustment to plans. Following surgery, the patient is discharged with post operative follow-up being carried out in the community by PCES. For this apparent simple pathway to work there are numerous administrative steps and departments to facilitate the smooth running of the pathway. Without organisational reform any pathways will struggle in implementation.

Integrated Eye Care

- 1. Work to break down barriers between primary and secondary care to deliver a fully integrated eye care service across Wales**
- 2. Recognise the need for robust integrated pathways to maintain clinical governance**
- 3. Integrated eye care pathways are delivered on a regional basis**

Eye care in Wales should move towards a fully integrated service with barriers between secondary and primary care removed for the delivery of NHS eye health services. In time this may lead to the development of a standalone eyecare division in operational services with pooled resources, budgets and governance. Progressing this ideal will require close working with colleagues in PCES to ensure that whole pathway systems are established to allow seamless transition of care. As PCES provide greater numbers of enhanced services this robust pathway governance becomes essential to providing safe and effective care. Pathway development also allows up to benchmark care and ensure that there is consistency in those providing care.

Integrated Eyecare also encompasses the support services needed by patients with visual impairment. People living with sight loss have very complex needs and those needs should be integrated into the end-to-end pathways of care.

Sustainable Delivery Model

Sustainable regional delivery of an integrated eye care pathway

The future of Ophthalmology in Wales can only be delivered on a regional platform. By maximising current resource and investing in future delivery of care Ophthalmology can move towards a position of strength in NHS Wales.

Estates

1. **Optimise current resources across regions**
2. **Centralise complex care in Ophthalmic specific estates and provide less complex care closer to home**

The current estates available to Ophthalmology services in Wales will be optimised to deliver rapid improvement in care, however this alone will not be sufficient to address the significant demand and capacity shortfall that exists.

Hospital buildings are a significant constraint to the way services are delivered. They control the amount of activity, size of workforce, efficiency of flow, and the opportunities for change and service improvement. Working spaces and environments can significantly influence the way staff and patients feel about services. In every unit physical space is a considerable limiter to the successful delivery of current services. With the proposed expansion of the workforce to tackle demand, the already constrained space will limit the potential these changes can deliver.

There cannot be any doubt that the future of Ophthalmology is regional delivery. The model of care to be adopted is central complex care supplemented by local routine HES and supported by PCES. Location of central services should be scoped appropriately but will require co-location with other secondary care services due to common interdependence of care in complex conditions. This will likely lead to self selecting sites in Swansea, Rhyl, and Cardiff. The use of current Ophthalmology sites for the delivery of central complex services is impossible. Current estates are, at very best, fit for partial delivery of local routine HES. Investment is needed in development of all sites however, moving complex care, to a central solution and moving high volume low complexity (HVLC) care out of routine delivery may reduce demand on local sites and subsequently reset the capacity need more aligned with current availability of estates.

However, commitment and investment is needed in the development and delivery of the remaining aspects of the model. Central hubs need to be fit for purpose, large enough to accommodate need, at the forefront of technology and advanced clinical care with enough space to train medical and non-medical colleagues and to allow predicted expansion of demand.

HVLC centres need to meet population demand and do not need to sit within acute care services and can be stand alone units. Within Ophthalmology HVLC includes routine cataract care and routine intravitreal injection services. Cataract care is a once or twice contact episode and patients may be willing to travel to receive care, however injection services require frequent attendance and the burden of travelling extended distances on a regular basis (can be monthly or 6 weekly) is unacceptable. Therefore different models for delivery need to be adopted for these aspects of care.

Electronic Patient records

Digital strategy for Eyecare

- 1. Roll out of fully integrated ophthalmology specific electronic patient record accessible in both PCES and HES**
- 2. Roll out eye care specific electronic referral system**
- 3. Roll out of Image sharing platforms allowing ophthalmic imaging data to be shared across PCES, HES and Health Board sites**
- 4. Effective data capture to enable accurate coding and booking of activity**

Digitalisation of eye care is fundamental to the delivery of transformational eye care services. Wales is behind the other UK nations with no fully functioning Electronic Patient Record (EPR) in any unit in Wales. Bespoke Ophthalmology EPR allow proper transformational change to occur. Previous attempts to implement an All Wales EPR have stalled due to various reasons and was moved into DHCW for delivery. However due to difficulties with contracting after a year of taking on the project the roll out of an EPR still hasn't been implemented. The current EPR underwent procurement processes following commissioning from DHCW and it remains the solution of choice for Ophthalmology in Wales and should be delivered at speed. The investment to this point in both finances and time must be recognised and any direction away from the original agreement should not be considered. Individual views from single clinicians should not be prioritised above approval from the national framework that now sits in place to drive Ophthalmic services in Wales. Unfortunately as this programme sits in DHCW the remit for this outside of the Clinical Implementation Network (CIN) for Ophthalmology. NCSOphth sees the delivery of an Ophthalmic EPR as an urgent priority.

Digital referral

A HealthCare Inspectorate Wales (HIW) review in 2016 highlighted the absence of digital referrals into secondary care as a significant governance risk and mandated the implementation of a digital referral system between PCES and HES. Eight years later there is still no functioning e-referral system in Wales. In addition to EPR, NCSOphth requests the urgent delivery of an electronic referral system in every unit in Wales.

Service data

By simplifying the coding used for Ophthalmic conditions, clinic codes and templates, data services within Health Boards can provide accurate demand data with the granularity required to design future services. By working with the coding and operational teams a standard approach to coding across Wales should be implemented.

Training and research

- 1. Increase Ophthalmology training places in Wales to align with RCOphth guidance**
- 2. Implement Ophthalmic Local Training across Wales to empower non-run through doctors to achieve their potential via portfolio registration**
- 3. Research will be integral to Eye care in Wales in primary care, secondary care and University settings**

A Sustainable future for Ophthalmology can only be achieved by investing dedicated time and resources into the training of the next generation of workforce. This is true for all levels of clinical and non-clinical staffing and will underpin the success of this blueprint. However, training of Ophthalmology trainees must be prioritised and must not be compromised by additional staff training requirements. Each Health Board will develop a plan on how they can meet the training needs of the department and a should have a dedicated Ophthalmic practice educator that is responsible for Ophthalmic specific training across the MDT workforce. Profession specific training should come under core standards of care.

Developing a Welsh Ophthalmic Local training (OLT) programme to allow doctors who are not on a formal training programme will be a huge attraction of workforce into Wales. The national recruitment of Ophthalmic trainees is one of the most competitive recruitment programmes in medicine and there are many who are not successful in securing a place or who have prioritised remaining in Wales above the possibility of having to move elsewhere in the UK to take up a training post. By developing an OLT

that can be delivered on a regional footprint would increase the attractiveness of Wales as a place to work and address the current workforce crisis that exists.

Case Study

Welsh Government invested £750,000 in the development of an Ophthalmic simulation suite situated in the School of Optometry and Vision Science in Cardiff University. This is one of the most sophisticated simulation suites in the UK and has been approved to host RCOphth surgical skills courses

Research

Research is fundamental to the future of eye care. In Wales, with the exception of Cardiff and Vale UHB, there is a poor tradition of clinical trials being undertaken in secondary care in Wales. Working with the new National Institute for Health and Care Research (NIHR) goals to target areas previously under-utilised for trial delivery we can expand the opportunities for our patients to access cutting edge clinical trials.

Primary care has also often been an area where research is undertaken sparsely however with the recent changes, the opportunity for research in primary care has never been greater. Working across boundaries the integration of research priorities and goals is achievable.

We are fortunate in Wales to have world class cutting edge Vision Science research institution in Cardiff University, advanced clinical research and health economics in Swansea University and qualitative and social care research in the Universities of South Wales and Bangor. Stronger relationships will be built to ensure that patients and clinical workforce have the opportunity to take part in such work. Collaborations across clinical networks can only strengthen the quality of research being carried out in Welsh Universities.

Requests

In order to drive forward transformation at speed immediate requests are made from our partners to support this development work;

Welsh Government:

- **Provide leadership and alignment of integrated eye care services across planned care and primary care policy and drive forward the full regionalisation of Eye Care in Wales by requesting performance and targets are met on a regional NOT health board basis. This will ensure Health Boards reconfigure their approach to HES to a regional challenge.**
- Promote and utilise the role of the National Clinical Lead for Ophthalmology, to drive strategic delivery across Wales using evidenced based clinical best practice.
- Establish or dedicate the role of a non-clinical National Director for Ophthalmology in NHS Wales Executive to demonstrate the specific focus for this clinical area and the transformation requirements set out. This role would also align, work with and support further enhancement to regional working in eye care across Wales, and ensure assurance from health boards on their commitment to improvement.
- To prioritise and fast track the implementation of an electronic patient record (EPR) via DHCW 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, and to ensure solutions are clinically led not based on cheapest or easiest options to implement.

Welsh Government is requested to endorse NCSOphth and make a firm commitment towards supporting the strategic ambitions for Ophthalmic Regional Services in Wales both through a policy driven and investment approach.

Health Boards:

- **Commit to true regional delivery mechanism for services in Wales, working without boundary constraints and as a single body.**
- **Actively participate in recommendations from NCSOphth and Clinical Implementation Network (CIN).**
- **Actively facilitate change and remove barriers towards improvements within secondary care Ophthalmology services.**
- Prioritise Ophthalmology Services within the annual planning cycles.
- Honour commitments already made to local and regional solutions and drive transformation ahead with urgency.
- Work with the current clinical workforce to maximise productivity and minimise variation in service delivery by implementing the clinical and management best practice recommendations.

- Increase and improve physical capacity and estates of Ophthalmology in secondary care wherever possible and not to downgrade the urgency of such needs.
- Aim to improve recruitment into secondary care eye care services and fund the expansion of the consultant workforce in line with RCOphth guidelines and recommendations.
- Provide data analysis support to Ophthalmology departments to ensure data and coding is robust and accurate information is available to manage the services.

HEIW:

HEIW has already shown commitment to the future of Ophthalmology training in Wales by advertising the first Head of School for Ophthalmology

- We ask for HEIW to support the expansion of the Ophthalmology training workforce according to the Royal College of Ophthalmologists (RCOphth) recommendations and work with operational teams and current medical workforce to accommodate the increased training needs.
- To consider non-medical eye care as a separate department within HEIW. Whilst there is an optometric lead, other professions fall into generic groups such as nursing who often are unaware of the differences in requirements in Ophthalmology specific training. Bringing all the professions together under a single eye care umbrella would cement the equity of access to training for all professionals that work in eye care as well as those who are un-registered but committed to undertaking further study in this very specialised area. This upskilling of our core workforce is integral to the success of NCSOphth.

NCSOphth Next Steps

To secure the future of Ophthalmic services adoption of this strategic view is fundamental to the delivery of a high quality, sustainable, integrated Eye Care Solution in Wales.

Going forward commitment is required to shape the detailed plans for the future as well as implementing transformational change that can start immediately.

This is the first high level strategic overview of the blueprint for transformation of Ophthalmic services. This initial report will be followed by a number of more detailed reports each looking at a focussed aspect of the delivery of HES. The planned reviews include:

- **Sub specialist reports and strategy**
 - Each of the sub-specialities will develop standardised pathways across Wales to ensure equality of care and equity of access for all eye conditions. These are:
 - Medical Retina and Uveitis
 - Glaucoma
 - Oculoplastics
 - Paediatric Ophthalmology
 - Cornea
 - Cataract
 - Emergency Eye care
 - Neuro-Ophthalmology and Adult motility
 - Vitreo-Retinal services
- **Workforce, training and research:**
 - A detailed workforce analysis and the development of a formal workforce strategy looking at medical and non-medical workforce, training and the needs surrounding this and the integration of research into Eye care in Wales
- **A digital strategy for eye care in Wales**
 - A full review of the way digital services can be integrated into care pathways to optimise the efficiency and effectiveness of services. This will include ophthalmic electronic patient records, digital referral systems, image sharing solutions as well as integration of wider operational digital solutions.
 - Detailed analysis of current demand and capacity issues will be attempted, however it is unclear if the granularity of data to carry out this with accuracy exists within the NHS in Wales. The clinical reference groups that will be established as part of the CIN will drive this element of the strategy to deliver the best evidence based quality of care across Wales and eliminate unwarranted variation.
- **Patient centred care**
 - Fundamental to care is ensuring that all transformation is patient centred and delivering to patient's needs. We have a close working relationship with patient groups and third sector partners including Wales Council for the Blind, Sight Cymru, RNIB and many other national and local organisations. We will work alongside them to ensure full equity for patients when services are being designed and developed and

to ensure that services across planned care are fully accessible for those with visual impairment.

Ophthalmology Clinical Implementation Network (CIN):

The Ophthalmology Clinical Implementation Network (CIN) is the vehicle for delivering the strategic aims of NCSOphth. However, it is in its infancy, and further resources are required to support its growth to deliver the future vision for Ophthalmology.

The principle aims of the CIN in the first 18 months will be:

- a focus on establishing clinical reference groups (CRG's) for the three highest volume services in secondary care; Medical Retina, Glaucoma and Cataract services and working towards standardisation of care across Wales.
- Nurture and grow the current multiprofessional workforce CRG and work with the patient communications subgroup to ensure accessibility in healthcare for patients with visual impairment.
- Develop a set of clinically lead metrics to allow meaning full outcome assessment of secondary care services.
- Work with other CIN's and the theatre optimisation team to address under use of current surgical capacity.
- Drive the WGOS reforms from a secondary care perspective and strive for them to realise their potential in the future of integrated eye care.



The formal programme will require adequate resources to take forward this substantial programme of work. This includes administration, planning and delivery teams dedicated to Ophthalmic transformation without distraction from commitment to other services.

Conclusion

There can be no doubt that the state of hospital eye services in Wales are currently at a tipping point. If nothing is done services will quickly reach crisis point, and patients in Wales will continue to come to harm from lack of access to expert services. However, change can be effective. There has been a groundbreaking move to provide eye care in Wales with a primary care service, the first in the UK and a support for hospital eye services that has never before been available. Whilst this will help with patients who are at lower risk of vision loss we now need to focus on the higher specialist care provided by secondary care services.

Evidence collected by this report has shown that there is a problem with collecting accurate data to measure services, with marked variation across Health Boards which limits ability to plan services and compare activity. Estates are not fit for purpose and too small to provide modern hospital eye services. There is no useful digital solution and roles and job plans are varied and disparate across Wales and clinicians have disengaged from change.

Building on this evidence a solution has been developed that provides a blueprint for the future delivery of Ophthalmic services in Wales. The National Clinical Strategy for Ophthalmology clearly lays down the groundwork needed for sustainable transformation of HES. The only future for Ophthalmology is true regional delivery of secondary care services. This is not a nod towards collaborative working but a true regional model of care with specific governance finance and planning in place. This can be rapidly facilitated by a move towards requiring Ophthalmology targets and plans to be delivered regionally and not within Health Board targets and boundaries. As this organisational reform takes place it will facilitate the move towards centralised highly specialised care that is supported by local delivery of less complex cases. Clinical networks and pathway changes will be evidence based, robust and peer reviewed to ensure equality of care and equity of access across Wales as we move towards a sustainable delivery model for the future. Investment will be needed, but this is not limited to financial investment. Time and commitment from all stakeholders is essential to facilitate change and must be integral to the solution.

The Clinical Implementation Network (CIN) will work with frontline operational teams to work towards delivery of many of the asks of NCSOphth but requires the support and leadership of Welsh Government to mandate change, and the executives of Health Boards to commit to an entirely different way of working. Without this the plan will fail, but with it, eyecare in Wales will become a gold standard in a fully integrated eye care service that cares for every person, at every level.

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Appendix 1. Patient Experience and Support

The content of Appendix 1 has been provided by RNIB and is fully endorsed by all third sector groups caring for patients with vision problems in Wales. We have a close working relationship with our third sector partners and highly value their input into the design and delivery of services.

Local and regional sight-loss organisations in Wales regularly report that patients are poorly supported to deal with their eye condition and the impact it has on their capacity to stay independent. By way of example, Vision Support published a case study [1] in 2023 of a patient in Conwy who was bluntly told by her consultant ophthalmologist “you are in the process of going blind so I’m discharging you, but if there are any changes call back”, and discharged with “no signposting at point of diagnosis, no emotional support or explanation but that she was simply moved on her way”. The patient reported that “Clinical staff did not provide information of support she could access and there was no ECLO (Eye Care Liaison Officer) present.”

Similarly, at a 2024 focus group in Cardiff of Sight Life’s members, some spoke of being discharged without signposting after being told that there was nothing more clinically that could be done. None of the participants reported being signposted or referred by an eye care professional other than via an ECLO. All discovered the support available either through their own efforts, those of a friend or family member, or a random conversation.

The members of the Wales Vision Forum (WVF) have, historically, identified gaps and issues with ensuring people have access to support, which is compounded by the increasing mismatch between the rising demand for eye care and the pressures on staff, estate constraints and financial resources to deliver it. This was strongly evidenced in the recent RNIB “Sight Loss Support Pathway” report [2] which concluded:

“If there was ever a point in time that NHS practitioners, eye care departments and specialist rehabilitation services required additional input and support from third sector charities it is now. The level of demand placed upon each practitioner, each department, each appointment has never been greater than it is today. Transformation is required across the whole end-to-end eye care pathway but, without better information, advice and support to ensure an individual is able to actively participate and take control of their eye care journey, other transformation priorities will fail.”

The third sector has a workforce with the expertise to collaborate with healthcare systems to identify such gaps and to transform the information, advice and support delivered across Wales. But to do that, and properly integrate third-sector services, eye care professionals need to consider non-clinical support as part of their overall care for a patient.

Recommendations

To ensure an integrated approach to strategic and operational eye care planning, we would recommend consideration is given, to improve patient experiences by:

Ensuring existing and new clinical pathways and Standard Operating Procedures (SOPs) contain explicit steps for health professionals to always consider what information, advice and support can be provided, signposted or referred into that would help maintain patient confidence and independence.

The outputs from this to be reported to health board Eye Care Collaborative Groups (ECCGs). The guidance and outputs should be co-produced with WVF members.

Strengthening the relationships between the health, social care and third sectors, through reinvigorated ECCGs that also include social care Vision Rehabilitation Specialists in their membership, alongside local and national third sector organisations. ECCG remits should include a responsibility to monitor and ensure referral pathways into third sector non-clinical services are working, and to coordinate the communication of information, advice and support offers from the third sector, so health professionals maintain knowledge of their local context.

Developing with WVF a three-yearly national eye care support pathway improvement plan, which forms part of every Regional Partnership Board planned delivery of eye care.

Integrating the principles of non-clinical patient support into postgraduate speciality and general practice training, and in CPD training, utilising the experience of ECLOs and WVF members.

Health Boards including ECLOs as part of their core ophthalmology workforce budget, with the number of FTE posts required determined as part of Regional Partnership Boards' Population Needs Assessments.

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Eye Care Liaison Officers (ECLO): Patient Support

Context

Consultant Ophthalmologist Mr Gwyn Williams (2022)

“The ECLO service is core to the holistic function of an eye department in the 21st century, such that any threat to its continuing would negatively affect the patients experience and diminish the support patients receive at a time of stress and anxiety”.

Pyott Report recommendation 7: Appropriate use of non-medical staff

Wales has made good use of non-medical staff. It is important that everyone is encouraged to perform to the top of their license. A unified approach is to be encouraged.

A Healthier Wales: our plan for health and social care

“Our vision is that everyone in Wales should have longer healthier and happier lives, able to remain active and independent, in their own homes, for as long as possible”.

Objective

To ensure patients have access to sustainably funded, quality-compliant Eye Care Liaison Officers (ECLOs) providing equitable non-medical patient support across hospital eye services. This includes reaching patients with other medical conditions which may impact vision such as diabetes and stroke.

What does an ECLO do?

ECLOs are a recognised and integral element of an excellent ophthalmology service. An essential part of the eye clinic team, ECLOs provide practical and emotional support to patients, their families, and carers, at the point of need. Improving the quality of the patient experience in hospital, ECLOs make timely and appropriate referrals to sources of additional support, to enable patients to live well with their sight loss.

Beyond the clinic, the ECLO is the link to information, advice, and support services which can enhance quality of life, improve understanding and self-care of eye conditions, and support independent living and wellbeing. ECLOs thereby play an important role in reducing health service expenditure in the medium and longer term, and a critical one in enabling people with sight loss to maintain or regain their independence.

ECLOs improve patient experience through advocating for better support for people with sight loss in clinic and across health, social care, and community support services. This may be through delivery of visual awareness training, facilitating training on how to support and communicate with patients with visual impairments, supporting clinics to adhere to Accessible Information Standards, or offering advice and guidance on the accessibility of the clinic environment.

ECLOs support the AGORED “Fundamentals of Ophthalmology” accredited training, leading on delivery of the “Introduction to Visual Impairment” module.

Our research shows:

- ECLOs improve the health and wellbeing of patients.
- ECLOs positively influence the quality of the patient experience in hospital.
- ECLOs provide vital information to help reduce the risk of falls.
- ECLOs encourage attendance at critical appointments and reduce non-attendance (DNA rates).
- ECLOs help distressed and vulnerable patients to start to come to terms with their situation, freeing up clinical resources to concentrate on medical interventions.
- ECLOs ensure patients get support in the community by supporting the timely completion of (often instigating) Certificates of Vision Impairment (CVIs).
- Patients feel reassured knowing that the ECLO service is available as a point of contact and a future source of support if required.
- ECLOs can support timely discharge of visually impaired in-patients.
- ECLOs improve efficiency in eye clinics.
- ECLOs are recognised as examples of outstanding practice in statutory inspections.

What the third sector offers:

- Over two decades experience delivering quality assured ECLO services across Wales.
- Expertise in delivery of practical and emotional support for people affected by sight loss.
- Up to date knowledge of the information, support, and services available to people with sight loss.
- Facilitating access to a range of third sector specialist information, peer support, interest groups, and self-help resources.
- Understanding of, and referrals to a range of primary and secondary care services including Low Vision Service Wales and Vision Rehabilitation.
- Membership of Wales Vision Forum, enhancing coordination of, and positive collaboration across, the sight loss sector.

Minimum standards of service delivery:

- Consistent terms and conditions of employment across all ECLO services.
- Successful completion of the City University of London-accredited Eye Care Support Studies qualification.
- Adherence to RNIB ECLO Quality Framework & Practice Guidance, which was developed in partnership with a range of ECLO providers and endorsed by the Royal College of Ophthalmologists and the UK Ophthalmology Alliance.

- Successful completion of mandatory training including visual awareness, safeguarding, personal safety, data protection.
- Access to support in recognition of the emotional impact of the ECLO's role, including peer support, supervision and training, resilience training, and access to clinical supervision.
- Access to professional networking opportunities and CPD.
- Full compliance with NHS Data Security and Protection Toolkit and GDPR and access to NHS systems (via Honorary Contract).
- Access to Locum ECLO to cover planned or unplanned absences, and manage peaks in demand, ensuring continuity of support for patients and staff alike.
- Data collection, reporting and evaluation that support standardisation of data for the purposes of comparison and benchmarking across Wales, including patient data, patient experience, and clinic staff feedback.

Recommendation:

LHBs will be mandated to include funding for an adequate, quality assured, ECLO services as part of their core ophthalmology service.

In line with Welsh Government drivers for eye care and support, now is the time to fully embed ECLO services as a core part of every eye department providing high quality patient care at the point of need.

The ECLO service enables clinicians to work to the top of their license in line with the principles of prudent healthcare, thereby freeing up capacity within secondary care.

Cost implications:

There are currently 10.8 FTE ECLOs plus 1 Locum ECLO supporting patients across Wales. In the absence of relevant population needs assessments via Regional Partnership Boards, using current performance data and service planning we anticipate the need for an additional 1.5 FTE ECLOs. These would be needed to provide adequate cover in Abergele, Singleton, and to support Noah's Ark Children's Hospital for Wales.

Based on NHS Grade 5 equivalent for a qualified ECLO, this is £35,490 per full-time ECLO, including on-costs (including the HCAS fringe rate). Each ECLO will support around 800 patients, their families, or carers, as well as professionals.

Additionally, a Wales-wide ECLO service would require the support of a further FTE Locum ECLO and an allowance for time spent by third sector organisations on management to ensure continuity of service provision for patients and clinicians, and Wales-wide service quality and consistency.

Appendix 2 : Consultation outcomes

Health boards context

The information below has been provided by Health Board Clinical leads (BCUHB, ABUHB, CAVUHB, SBUHB) and service leads (HDUHB AND PTHB) to provide a picture of services from a frontline clinical perspective.

Hywel Dda UHB

Population: approximately 385,000

RCOphth recommended number of consultants: 11.5

Number of (FTE) consultants: 3

HDUHB covers three counties of Carmarthenshire, Pembrokeshire and Ceredigion and serves a population of 385,615. The Ophthalmology service is delivered out of 9 sites within the HB.

The service has only 3 substantive consultants. RCOphth guidelines on workforce would recommend 11.5 FTE for the population. Given the paucity of substantive consultants HDUHB is currently unable to support the ophthalmology training grade doctors and relies on costly locum consultants who have little investment in service development and improvement. HDUHB has a strong working relationship with optometrists in both primary and secondary care who are currently responsible for a not insignificant proportion of patients. Despite this demand cannot be met and services continue to be at risk, highlighting that optometric support, even at the highest level cannot save Ophthalmology services.

The cataract service is delivered out of 3 theatre sites across the region but only provides 8 lists a week with an average of 4 cases on a list which is below the GiRFT recommendations. There is no consultant support of cornea services and requires referral out of the HB for management. Injection services are supported by 1 substantive consultant, 5 locum consultants and 7 SAS doctors and has worked hard to address the significant backlogs. There are already well established shared care schemes with community optometry services that will be expanded as part of WGOS 4 implementation.

Paediatric Ophthalmology and emergency eye care does not have any substantive cover and relies on locum consultants and patients moving across HB boundaries.

Betsi Cadwaladr UHB

Population: approximately 700,000

RCOphth recommended number of consultants: 21

Number of (FTE) consultants: 14

BCUHB is the largest health Board in Wales both geographically and in terms of population served. It was formed in 2009 but ophthalmology services are still delivered by three separate units corresponding to historic hospital boundaries of Ysbyty Gwynedd (Bangor), Ysbyty Glan Clwyd (Abergele) and Ysbyty Maelor (Wrexham).

Medical and nursing staff are recruited by and work in a designated unit. Each unit has its own operational and administrative team. There is little communication between sites and no vision for how safe equitable secondary eye care can be achieved for the whole population.

Bangor Eye Unit is located within the DGH and has one operating theatre. There is limited space, and all intravitreal injections take place in the operating theatre displacing cataract capacity. Bangor has significant difficulty in recruiting consultants and has relied on locums for over 10 years. Abergele is the largest unit and located on a site remote to the DGH. It has two theatres and two IVT treatment rooms. The estate is in poor repair. Wrexham Eye Unit is located within the DGH. It has one theatre and one treatment room. Outpatient space is not adequate. Historically eye clinics were also run at Deeside, Ruthin, Holywell, Royal Alexander and Colwyn Bay hospitals but these were largely lost during the Covid-19 pandemic and not been reinstated due to lack of staff. Clinics at the Additional Needs Ysgol Y Gogarth have similarly been lost.

All main sites run outpatient clinics, injection clinics, and offer cataract surgery however most sub-specialist surgeries take place in the Abergele including all vitreoretinal surgery. Patients under the care of Bangor or Wrexham needing specialist surgery must be referred to the Central site and seen again before listing.

Out of hours care is delivered separately by the three sites however one site cannot now staff a first on-call rota. Discussions on regional cover are ongoing but there are challenges due to the size of the Health Board and distances between the three ED's.

Much work has gone into reviewing GIRFT recommendations with attempts to start HVLC cataract surgery. The financial situation of the Health Board has limited recruitment for vacant or new posts which has particularly affected theatre and administration staff.

As the three sites function as siloes. Patient pathways and medication accessibility differ across the region resulting in a "Postcode Lottery" within one Health Board

Cwm Taf Morgannwg UHB

Population: approximately 450,000

RCOphth recommended number of consultants: 13.5

Number of (FTE) consultants: 8

(No response received from CTMUHB brief overview from NCSOphth authors)

Services are provided on a number of sites including Princess of Wales Hospital Bridgend and Royal Glamorgan hospital in Llantrisant. Recent HB restructuring has left a completely fragmented service with a North and South with no workforce cross over and hence a significant variation in service delivery across the HB. Services in RGH are particularly fragile with significant limitations placed on delivery of theatre services, cataracts in particular with practice lying well outside of GIRFT recommendations. Both cataract and glaucoma services have required outsourcing to manage significant patient risk.

Cardiff and Vale UHB

Population: approximately 472,400

RCOphth recommended number of consultants: 14

Number of consultants: 13

Ophthalmology unit within CAV HB is located in the University Hospital of Wales and delivers comprehensive ophthalmic service not only to the local Cardiff and Vale population but also serves as a tertiary referral centre for complex orbital/ oculoplastic cases, complex glaucoma, paediatric ophthalmology, neuro-ophthalmology, ocular genetics, uveitis and vitreoretinal services. In addition, UHW ophthalmic unit provides medical retina service and IVT treatments for AMD and diabetic patients from Princess of Wales Hospital (CTM). UHW already provides some regional ophthalmic services but regional working (creation of Centre of Excellence with regional hubs) as well as how these services are funded needs to be further developed. Currently ophthalmology unit in UHW consists of clinic 1, 7 and 8. Additional clinics are undertaken in paediatric and dermatology units as well as Cardiff University Optometry School. This is a result of limited space in the UHW and outdated facilities in the hospital with multiple estate issues. There are 2 minor ops rooms in main outpatients, used for procedures like crosslinking, minor lid procedures, IVTs and botox injections but frequently use of minor ops rooms is affected by recurrent leaks leading to cancellations of clinical activity. Additionally on multiple occasions clinic corridors are made even narrower by buckets placed in the middle of corridor to collect water from yet another roof leak. This is hardly a suitable space for delivery of care to visually impaired patients. In terms of theatres, currently ophthalmology uses theatre 3, 8 and twin mobile theatres (Vanguard) with enough workforce to fully support use of all this operating space. Paediatric lists are undertaken in children unit within UHW. In last 12 months we have been involved in delivering regional cataract service by utilising twin mobile theatre unit (Vanguard). In line with GIRFT recommendations we have made improvements to the cataract pathways, which have resulted in increased numbers on the lists. However, with loss of cataract theatre infrastructure (Vanguard is due to be removed in July 2024) we are facing challenges in how

we can sustain both our workforce as well as continue supporting cataract services to the same standard. With loss of Vanguard and its operating space ophthalmology in UHW will only have two operating theatres; one of which is unsuitable to support any high-volume cataract lists and the other that frequently gets affected by temperature problems affecting utilisation of this space. Without maintaining theatre facilities to match the current number of operating lists and improving the existing theatre facilities ophthalmology in UWH will not be able to continue delivering regional cataract service nor expand into fully functioning VR service that can deliver VR emergency services for Southeast Wales. We are due to appoint additional VR consultant and are getting a business case ready for one more VR post. With these appointments we could deliver full 5 days of VR operating but only if we have a sustainable operating space to do so, and one big enough that can accommodate all the subspecialty and cataract work we currently undertake.

Aneurin Bevan UHB

Population: approximately 600,000

RCOphth recommended number of consultants: 18

Number of (FTE) consultants: 11

ABUHB delivers services to the largest population in South Wales. Ophthalmology services are delivered across a number of sites within the health board leading to a fragmented and high demand service. This was further compounded by the opening of the Grange University Hospital in November 2020. Currently the main site is at the Royal Gwent hospital. Here there are two operating theatres providing 20 sessions of ophthalmology specialist surgery and outpatient clinics. Other hospital sites include Neville Hall hospital, where there are currently 3 theatre sessions provided by generic theatre staff and an outpatient and intravitreal injection (IVT) service, and Ysbyty Ystrad Fawr for outpatient and IVT services. There is a stand alone IVT service provided via rental of private space in the centre of Newport town Centre. Pre-pandemic, other HB sites were also used to provide both medical and support services including Chepstow and Ebbw Vale hospitals. Whilst the fragmentation of services exists there is a single consultant body providing the care across the HB unified under a single clinical lead and directorate manager with significant experience in Ophthalmology and understanding of the nuanced and specialist care that makes Ophthalmology different to many specialties. Whilst some activity has returned to pre-pandemic levels surgery remains at around 70%. There is no sustainable approach to ensuring the full utilisation and back fill of empty lists.

ABUHB response to GiRFT has been to develop the cataract service provision in NHH and to continue to work with CAVUHB and CTMUHB towards the delivery of regional cataract services. They have also undertaken an extensive reworking of glaucoma pathways and service delivery utilising the MDT approach to care. Whilst they also have plans to adopt this approach with other sub specialities they are constrained by workforce and estate limitations. By adopting consultant delivered services across all hospital sites they are restricting the capacity of clinical activity due to limited support staff across multiple HB sites. Furthermore, the main site of RGH lacks the physical capacity to provide the space required to accommodate the current consultant body which is below the RCOphth recommendation. This is true of both outpatient and theatre capacity. Twenty theatre sessions are not enough to provide regular job planned sessions to the current Consultant workforce and therefore limits ability to attract

or employ the required number. These space constraints also limit the ability of the consultant team to expand MDT working or provide training to those who require it.

Emergency eye care is busy and at risk in ABUHB with most of the emergency service being delivered by junior or locum doctors. There are regular gaps on the junior doctor on call rota that requires locum fill in, and due to senior workforce issues there are on-going gaps in the consultant on call rota that require locum fill. Emergency eye care in ABUHB had failed to recruit a specialist consultant. It is delivered at the main Ophthalmology unit in RGH however covers the entirety of the HB. Prior to the opening of GUH the on-call junior doctor was able to continue with elective work as required as the main Emergency Department was co-located at RGH, however with the movement of acute services to GUH, where Ophthalmology has no active presence, the on-call junior now has to be available to travel across sites in the HB to provide the on call service resulting in reduced elective activity.

The standard of estates is also questionable with a catastrophic flood causing extensive damage throughout the department in RGH occurring in 2023. Furthermore, the theatre space located on the top floor requires lift access in order to operate. The lifts have stopped working numerous times during 2023 with only one lift currently functioning and plans in place to only replace a single lift. In NHH there are issues around RAAC, poor ventilation and estates which are not fit for purpose in a modern Ophthalmic practice.

Swansea Bay UHB

Population: approximately 390,000

RCOphth recommended number of consultants: 12

Number of consultants: 12 (1 retire and return)

SBUHB delivers services to the population of Swansea, Neath Port Talbot and southern parts of Powys. Ophthalmology services are delivered across a several sites including Singleton Hospital, Neath Port Talbot Hospital, Dyfed Road HC, Morriston Hospital Paediatric theatres and Ystradgynlais Hospital. There are generally good communications across sites and well co-ordinated working. The main provision of eye services is located in Singleton Hospital with the other sites essentially supporting diagnostic and outpatient consulting facilities.

Despite its dominant role in the service provision the Singleton Hospital site manifests a significant number of drawbacks with the department spread distantly over 7 locations requiring duplication of imaging and other equipment and facility. The lack of connection results in inefficiency, wasted time and confused patients. Many of the corridors were designed in the 1960s and are narrow and unsuitable for visually impaired people. There are also problems with inadequate seating and lighting. The hospital is poorly located for most of the served population being on a seafront with relatively poor transport links.

Singleton Hospital eye services comprise of 3 separate outpatient corridors, an urgent care corridor, an inpatient ward, 3 day-case theatres (which are shared and periodically requisitioned by other specialities including orthopaedics and plastic surgery), along with one inpatient theatre available for 5-6 sessions a week (which has also been requisitioned by the HB for the use by other specialities e.g. bariatrics). There are not enough operating theatre sessions to accommodate

the consultant workforce and there are fewer than before COVID. The day-case theatres are located over a main public highway which means that in effect they are treated as a remote location. As a consequence, it is difficult to arrange general anaesthetic cases (e.g. squint surgeries) and patients have to be fit and have to have surgery scheduled for morning theatres. A theatre back-fill (of empty operating lists) operates within the department to try to maintain capacity and theatre occupancy, but full utilisation is not always possible. Theatre lists are usually well utilized and full but due to staffing issues initiative pre-operative assessment clinics are intermittently required.

Minor operations are now performed in some of the larger consulting rooms but there is no dedicated facility for this nor botulinum clinics. One of the outpatient corridors is 2 floors away at the diametrically opposite end of the hospital building from the main outpatient areas. The inpatient ward is distant and 3 levels above the main outpatient areas and the inpatient operating theatre 2 levels above the main outpatient areas. Intra-vitreous injection services are provided in one of the outpatient corridors but are not well suited for visually impaired people.

Neath Port Talbot Hospital provides outpatient clinical activity and orthoptic and glaucoma assessments. There have been recurring staffing issues since COVID when other disciplines have moved into the facility.

The eye emergency service constitutes an Urgent Referral Clinic for Eyes located in Singleton Hospital which sees only referred patients or those given direct access for clinical reasons. The on-call out of hours team varies between 2-3 tier and covers the main acute, trauma, burns and plastics centres at Morriston hospital. On-call doctors frequently have to travel to Morriston to assess patients using only portable / handheld equipment as there is still no formal ophthalmic presence in Morriston Hospital.

The single consultant body is employed by SBUHB providing care across the HB. There is a single clinical lead ophthalmologist, an operational service manager and clinical service manager who both have extensive experience of ophthalmology. The ophthalmology directorate itself is irrelevantly paired with Breast Surgery within the current management structure.

The department collects probably the best demand and capacity data of all Welsh HB's and the directorate manager produces excellent activity predications that allow accurate planning of service needs and patient targeting. The HB and consultant body are fully behind the principle of regional eye-care services and provided that realistic and funded proposals can become a reality, they are expecting to enlarge the workforce and deliver eye-care to the whole of south west Wales. Such an undertaking which will solve the entrenched problems that our neighbouring health board and its patients, have suffered over many years as inadequate facility and weak management have resulted in a downward spiral of inadequate staffing (recruitment and retention of senior medical personnel), the costly reliance upon locum grade doctors and difficulties providing out of hours and emergency eye-care cover.

Powys THB (service lead)

Population: approximately 133,000

RCOphth recommended number of consultants: 3

Number of consultants: 0

Powys has no Consultant Ophthalmologists working directly for the Health Board and patients rely on visiting doctors for outpatient appointments and IVT. For subspecialty care or surgery they must travel outside the Health Board to sites in Aneurin Bevan, BCUHB or across the border in England. The system is complex and fragile with risks incurred due to administration and contract change. Patients with visual impairment can often not travel independently so the system impacts carers and Hospital Transport as well as the environment.

Powys Teaching Health Board is responsible for improving the health and well-being of approximately 133,000 people. Powys is very sparsely populated and rural, with 5% of the population of Wales, but spread over a quarter of the landmass. There is no District General Hospital within the Health Board, resulting in one of the most unusual and complex environments in the UK with patients travelling to more than 15 other NHS organisations spanning five health economies across England and Wales. Approximately half of the secondary care flows including ophthalmology involve NHS Trusts in England (Wye Valley NHS Trust and Shrewsbury and Telford NHS Trust).

Secondary care ophthalmology services are provided for Powys patients by in-reach consultants commissioned from Wye Valley NHS Trust, Hywel Dda UHB, Shrewsbury & Telford NHS Trust, Swansea Bay UHB. There is no provision for specialist urgent care outside of the capabilities of general nursing at Minor Injuries Units across Powys. Initial management of urgent eye problems is conducted in primary care EHEW services, with additional service provided from independent prescribing optometrists. Diagnosis and management of more complex urgent eye conditions requires the patient to travel outside Powys with most of the flow into England.

Services in Powys are provided across the county at hospital sites utilising in-reach consultants and Powys employed multidisciplinary teams or nurses, optometrists and ophthalmic scientists. There are two well equipped lamina flow theatres in Powys (1 Brecon, 1 Llandrindod) and eyecare outpatients are provided from community hospital sites across Powys these facilities are shared across all Planned Care specialities. The day case estate provision is excellent and currently underutilised whilst further improvements additional space is required in terms of OP estate.

There have been significant transformational developments in eyecare provision and PTHB eyecare MDT supported by OP Transformation funding enabling the development of a small eyecare MDT to support service sustainability and fragility of in reach, team consists of optometry, health scientist, specialist nurses with training opportunities and career pathways developed for staff to train and retain in PTHB with networked support from DGHs. This MDT approach has provided core infrastructure to commence the repatriation of patient pathways from DGH providing care closer to home care closer to home for patients, instant diagnostics for decision making for clinicians and improved access times to support RTT management. Theatre staffing is fragile, and the team works across Planned Care specialities, work is on-going to review theatre staffing as part of GIRFT recommendations and a gold team approach is currently being piloted for eyecare lists. There is significant opportunity for repatriation of patients back to PTHB to support regional capacity this will

require continued investment in staffing infrastructure with bids to National Planned Care fund to supporting this requirement.

PTHB has been well supported in terms of WG capital for equipment, however, to increase capacity more will be required in addition to on-going replacement programmes. PTHB is keen to support role out of Digital Health solutions as part of service transformation and is fully engaged with National Digital workstreams.

Waiting lists with PTHB are generally within WG access targets however in reach services are fragile and PTHB residents are within cohorts of long waiting patients at DGHs.