Welsh Parliament
Health and Social Care Committee

Inquiry into Ophthalmology Services in Wales

November 2025

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About the Committee

The Committee was established on 23 June 2021. Its remit can be found at:
www.senedd.wales/SeneddHealth

Current Committee membership:

Committee Chair:
Peter Fox MS
Welsh Conservatives

Mabon ap Gwynfor MS
Plaid Cymru

James Evans MS
Welsh Conservatives

John Griffiths MS
Welsh Labour

Lesley Griffiths MS
Welsh Labour

Joyce Watson MS
Welsh Labour

The following Member was also a member of the Committee during this inquiry.

Russell George MS
Independent Member

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Chair's foreword

Half of all sight loss is avoidable with early detection and timely treatment.

Yet, currently, more than 80,000 patients in Wales at the greatest risk of permanent sight loss are waiting longer than they should for sight saving treatments. And demand for services is growing, estimated to rise by up to 40 per cent over the next 20 years.

During this inquiry, we heard powerful testimony from patients about the emotional and practical consequences of delayed treatment for all aspects of their lives, and the fear they have of losing their sight altogether. We are so grateful to them for sharing their experiences with us, and we hope that our report will act as a catalyst in hastening the improvements that are so desperately needed.

The National Clinical Strategy is the long-term, detailed blueprint for reforming eye care services in Wales. Published in September 2024, it provides a clear, strategic direction for the development of ophthalmology services. There is strong support for the strategy, but concern about the slow progress being made in delivering it.

Given the scale of the challenge, the Welsh Government must act with urgency to ensure the strategy is fully implemented, with clear milestones and deadlines for delivery, a commitment to sustainable investment in NHS services to deliver reforms, and clear accountability structures to monitor delivery. Crucial to this will be ensuring that patient experience and support are embedded throughout the delivery of ophthalmology care.

Peter Fox MS
Chair, Health and Social Care Committee

Recommendations

Recommendation 1. The Cabinet Secretary should, as a matter of urgency, establish a dedicated, cross-sector oversight board for ophthalmology to monitor the implementation of the National Clinical Strategy. The board should:

- include representatives from the Royal College of Ophthalmologists, health boards, HEIW, DHCW, optometry leaders and patient groups;
- be responsible for tracking progress with implementation against clearly defined milestones; escalating risks with delivery; and reporting publicly on outcomes;
- be established prior to the Welsh general election in 2026. ..... Page 31

Recommendation 2. The Cabinet Secretary should, in February 2026, update the Committee on progress with implementation of the National Clinical Strategy, including:

- details of any agreed key milestones, and progress with their implementation (including who has responsibility for their delivery);
- any risks identified with delivery of those key milestones. ..... Page 31

Recommendation 3. The Welsh Government must commit to a programme of investment specifically for secondary ophthalmology services which mirrors the scale and sustainability of the investment made in primary care optometry. This programme should cover estate and accessibility improvements, equipment replacement cycles and workforce expansion and retention initiatives.....Page 31

Recommendation 4. The Cabinet Secretary should, in February 2026, update the Committee on progress against the Welsh Government's target of creating 30,000 primary eye care appointments per full-year cycle and demonstrate how secondary care reforms are being aligned with WGOS success.....Page 31

Recommendation 5. The Cabinet Secretary should commit to ensuring that waiting list data for ophthalmology is captured at a sub-specialty level to inform effective service planning, support smarter resource allocation and help to reduce patient harm.....Page 32

Recommendation 6. The Welsh Government and NHS Wales should ensure that patient experience and support are embedded throughout the ophthalmology care pathway. This should include:

- full implementation of the eye care support pathway, ensuring patients receive timely information and emotional support at every stage of their care journey;
- a review of the likely benefits of including eye care liaison officers in workforce planning in order to ensure sustainable funding and consistent provision across all health boards;
- strengthening the role of the patient voice in service design, monitoring and evaluation, including representation on regional eye care boards and clinical networks;
- ensuring equitable access to services, particularly for patients in rural and underserved areas. ..... Page 41

Recommendation 7. The Cabinet Secretary should, by the end of February 2026, update us on progress with the development and implementation of a standardised harm reporting protocol across all health boards, including details of any targets and milestones. As part of this, he should:

- confirm that appropriate training will be provided for health board staff to ensure the accurate capture of harm incidents, and
- provide details of the monitoring arrangements he intends to put in place to ensure that, once implemented, the protocol, is being followed by all health boards. ..... Page 42

Recommendation 8. In his response to this report, the Cabinet Secretary should provide an update on progress with the implementation of the OpenEyes digital system against the March 2026 target. Specifically this update should include details of:

- the health boards where the system has been fully implemented across all subspecialities;
- the health boards where implementation is in progress but not completed (and details of the completed and outstanding subspecialities), and

- the health boards where implementation has yet to begin. ..... Page 54

Recommendation 9. The Cabinet Secretary should make an oral statement in March 2026 about implementation of the OpenEyes digital system. This statement should:

- confirm clearly whether the March 2026 deadline has been met and the OpenEyes digital electronic patient record has been fully implemented across all health boards and subspecialties, in line with the Welsh Government's target;
- provide a full explanation for any delay in meeting this target, including revised timelines and actions being take to address outstanding implementation, and include a breakdown of implementation by health board and subspecialty.
- provide an update on progress with the implementation of the electronic patient referral system in all health boards. ..... Page 54

Recommendation 10. The Welsh Government must be stronger in directing the regional delivery of ophthalmology services in Wales, as set out in the National Clinical Strategy. It must:

- develop and publish a set of expectations for implementation of the regional model provided for in the national strategy, with defined milestones and targets to track progress against delivery;
- require ophthalmology-related targets and plans to be delivered on a regional basis;
- ensure the necessary governance and infrastructure arrangements are put in place to underpin a sustainable regional delivery model of secondary eye care in Wales;
- commit to a multi-year, ring-fenced investment programme for secondary care that matches the scale and ambition of the recurrent funding already provided to reform primary care optometry. This investment should support the development of a sustainable regional eye care model, including estate upgrades, equipment replacement, and workforce expansion and retention, as set out in the National Clinical Strategy for Ophthalmology. ..... Page 61

Recommendation 11. In response to this report, the Cabinet Secretary should set out the arrangements that are in place for the Welsh Government to have oversight of the progress of the regional eye care boards in implementing the National Clinical Strategy, including details of any regular reporting requirements. He should also commit to publishing details of the progress of these regional boards. Page 61

Recommendation 12. Welsh Government and NHS Performance and Improvement should require health boards to demonstrate that they are:

- maximising the current ophthalmology estate, including implementing improvements that have been proven to work elsewhere and submitting business cases for capital investment where appropriate,
- developing and maintaining a rolling equipment replacement schedule, informed by clinical need and service demand, to ensure timely upgrades and avoid service disruption;
- working with NHS Wales Shared Services Partnership (NWSSP) to explore opportunities for centralised procurement, shared asset tracking, and coordinated capital planning.

Health boards should be required to write to our successor committee in twelve months' time to report on progress in these areas, including:

- the condition and suitability of their ophthalmology estate;
- planned and completed equipment upgrades;
- any outstanding risk to service delivery due to estate or equipment limitations. Page 67

Recommendation 13. In its response to this report, HEIW should provide us with an update on the work of its specialty school for ophthalmology and the Head of School. This update should include:

- progress with initiatives to improve recruitment and retention of ophthalmology trainees and consultants;
- actions taken to promote ophthalmology as a career;
- steps to expand the ophthalmology training programme, including any curriculum developments or new training pathways;

- details of progress with developing a specific trainee recruitment programme for Wales, including timelines and expected outcomes, and
- key performance indicators to track progress, such as number of new training posts created, percentage of trainees retained in Wales post-CCT, uptake of enhanced training opportunities and regional distribution of trainees and posts. ..... Page 78

Recommendation 14. In its response to this report, HEIW should provide us with an update on the specific actions being undertaken to address training capacity limitations in ophthalmology, including:

- milestones for expanding training infrastructure and supervision capacity;
- plans for a phased increase in specialty training places, aligned with projected demand and workforce modelling;
- any barriers to expansion and proposed solutions. ..... Page 78

Recommendation 15. The Cabinet Secretary should commit to providing funding for additional ophthalmology specialty training places identified by HEIW in its annual education and training plan, ensuring sustainability and alignment with the scale of investment already made in primary care optometry..... Page 78

Recommendation 16. In its response to this report, HEIW should provide us with an update on its ophthalmology workforce review, including timelines for completion and early findings. ..... Page 79

Recommendation 17. HEIW should commit to producing a strategic, cross-professional workforce plan for ophthalmology, covering medical, nursing, optometry and allied health professionals. This plan should:

- be informed by regional demand modelling and workforce data;
- include actions to improve retention post-CCT;
- identify future workforce needs across subspecialties;
- be published before the end of February 2026. ..... Page 79

1. Introduction

1. Ophthalmology is the medical specialty dedicated to diagnosing, treating, and surgically managing eye diseases and disorders. It encompasses a wide range of services, including cataract surgery, glaucoma treatment, management of macular degeneration, diabetic retinopathy, corneal conditions, and retinal disorders[1].

2. In Wales, ophthalmology services are under significant pressure. This specialty has the highest number of patient pathways awaiting treatment and the second greatest number of pathways with waiting times exceeding 53 weeks.

3. Due to these prolonged waiting times, many patients face the risk of severe vision impairment or sight loss from delayed treatment. It is this critical issue that prompted the Committee to undertake this inquiry, aiming to understand and address the factors contributing to these extended waits and their serious consequences.

Our inquiry

4. On 20 February 2025, we issued a call for written evidence based on our agreed terms of reference. These included consideration of:

- Organisational reform and service efficiency: examining the Welsh Government's efforts to integrate primary and community care optometrists into the eye care service model, focusing on redesigning referral pathways to improve patient access, while also evaluating how government policies support health boards in making these changes and aligning leadership to drive improvements.
- Workforce expansion and training: reviewing the Welsh Government's efforts to increase training capacity, expand roles for optometrists and other healthcare professionals, and evaluate the impact of the All Wales International Recruitment Programme on staffing shortages. Assess how workforce initiatives align with the National Workforce Plan and the effectiveness of investment in transforming the optometry workforce to reduce reliance on hospitals.

[1] Annex 1 provides a glossary of common eye conditions

- Hospital and infrastructure improvements: reviewing the progress with upgrading hospital facilities and addressing outdated spaces, investigate delays in implementing digital systems like the ophthalmic EPR and eye care referral systems, and assess funding and outcomes for infrastructure improvements in primary and secondary care. Investigate the impact of delays implementing improved digital systems and their interoperability. Assess plans to meet growing demand in ophthalmology, including the use of telemedicine and AI tools to improve care.

- Clinical Networks and equal access to care: reviewing the establishment of clinical networks to ensure equal care across regions, addressing disparities in care delivery and waiting time performance. Evaluate the Welsh Government's approach to regional service and workforce distribution, and how clinical networks can improve collaboration between health boards and patient outcomes. Also, assess the effectiveness of new care pathways in prioritising high-risk patients and using community-based optometrists for non-complex cases. Finally, examine collaboration between health boards and third-sector organisations, such as the Eye Care Support Pathway, to ensure holistic patient support.

- Oversight and implementation: evaluating the Welsh Government's oversight of strategy implementation, including leadership commitment at the health board level. Assess the role of Digital Health and Care Wales (DHCW) in accelerating IT system rollouts.. Investigate how delays and inefficiencies are being addressed, and what penalties or corrective measures are in place for missed timelines.

5. We targeted a number of relevant stakeholders and received 12 responses. We subsequently held a series of oral evidence sessions, which concluded with a scrutiny session with the Cabinet Secretary for Health and Social Care. Full details of these sessions and the written evidence that informed them are available on our website.

6. We would like to thank all of those who contributed to this inquiry, particularly those patients who shared their stories with us so bravely.

2. Ophthalmology services in Wales

> *"The constant fear I have, which I live with daily (…) is of going blind. They're literally leaving the dark, permanent dark, in my eyes."*
>
> *Edward Kenna, 80, patient with macular degeneration*

Background

7. In 2019, the Welsh Government introduced clinical prioritisation targets known as the 'Eye Care Measures for NHS Outpatients' after RNIB Cymru raised concerns about capacity and demand issues in ophthalmology services. RNIB Cymru highlighted that patients were waiting too long for both initial and follow-up appointments.

8. Wales was the first country in the UK to implement these clinical prioritisation targets. The Eye Care Measures aimed to prioritise urgent cases over traditional referral targets, ensuring high-risk patients received timely treatment. This is crucial as many patients need to be seen sooner than the 26-week target in order to prevent irreversible harm. All patients are now categorised by clinical need and are given individual target dates.

9. Health boards aim for 95% of the highest-risk patients[2] to be seen within their clinical waiting time to avoid permanent sight loss. However, in January 2025, more than 80,000 patients at the greatest risk of permanent sight loss were waiting longer than their target date for sight saving treatments.

Eye Care Measure data

In their written evidence, RNIB Cymru include a table outlining eye care measure data by health board. In January 2025, the:

- total number of patient pathways assessed as being at highest risk of irreversible harm waiting for an appointment was 161,902.
- total number of patient pathways assessed as being at highest risk of irreversible harm waiting beyond target date was 80,826.

[2] These patients are classified as 'R1': at risk of irreversible harm

- percentage of patient pathways assessed as being at highest risk of irreversible harm waiting beyond target date was 49.9%.

The Pyott Report

10. In 2021, Dr. Andrew Pyott published his report titled "External Review of Eye Care Services in Wales," which was commissioned by the Royal College of Ophthalmologists to assess the state of ophthalmology services in Wales and provide recommendations for improvement.

11. The report highlighted areas of best practice, including for glaucoma pathways and macular services, training programmes for technicians in imaging and data capture, the rollout of the Open Eyes digital platform for patient records, and the increase in independent prescribing practitioners.

12. The report also identified several inefficiencies and areas needing significant improvement, including:

- Staffing Shortages: Difficulty in recruiting and retaining staff in certain locations. Dr Pyott recommended consolidating hospital eye care departments due to recruitment challenges. He said Wales is understaffed in sub-specialties like vitreoretinal and corneal surgery, and lacked trained nurses. He raised concerns about large numbers of patients who were sent to Bristol for out-of-hours surgical provision, costing £500,000 to £750,000 annually.

- Infrastructure: Current facilities are insufficient for demand and projected growth. Most eye care departments need more space and equipment. Dr Pyott advised creating three purpose-built Centres of Excellence for equitable access. He said expanding existing capacity was limited by the current estate.

- Pathway Redesign: Dr Pyott recommended a complete redesign of patient pathways including reorganisation across health board boundaries to better serve patients and staff. He called for the repatriation of patients who travel to hospitals in England for treatments like vitreoretinal surgery, uveitis, electrophysiology, cornea, and some strabismus. He advised optometrists could help manage glaucoma, macula service, and paediatric refraction and there should be a focus on enhancing community training and increasing the number of Independent prescribers.

13. The report included 10 recommendations and influenced the National Clinical Strategy for Ophthalmology, published by NHS Wales Executive in September 2024.

Referral to treatment times

14. In April 2022, the Welsh Government set planned care recovery targets[3] to eliminate patient waits longer than a year by Spring 2025 for most specialties, and to eliminate waits longer than two years by March 2023. Performance data is published monthly.

15. In April 2024, there were over 104,000 patient pathways in Wales waiting for an ophthalmology appointment. By the end of March 2025, this number had increased to 108,073 patient pathways waiting. This has since fallen slightly, with latest statistics showing that, in August 2025, there were 103,610 ophthalmology patient pathways.

National Clinical Strategy for Ophthalmology

16. In 2024, the Welsh Government and the NHS Executive Strategic Programme for Planned Care commissioned a National Clinical Strategy to provide a long-term, detailed blueprint for reforming eye care services in Wales.

17. Published in September 2024, the National Clinical Strategy for Ophthalmology[4] highlighted significant pressures on services across the UK, with Wales facing a "particularly alarming" situation. Ophthalmology waiting times were the highest among all medical specialties, raising serious concerns about adverse outcomes for patients, including the risk of avoidable sight loss.

18. The Strategy noted that, over the past decade, the number of people waiting for an ophthalmology appointment in Wales had surged by 169%. Unlike in England or Scotland, there were no indications that waiting lists in Wales were beginning to decrease.

19. The National Clinical Strategy outlined several of the challenges which are contributing to long waiting times in Wales, including a growing demand for services (resulting from an increasingly elderly population and increased

[3] *'Our programme for transforming and modernising planned care and reducing waiting lists in Wales'*, Welsh Government, April 2022
[4] National Clinical Strategy for Ophthalmology, 'Delivering the Future of Ophthalmology in Wales', *September 2024*

incidence of eye disease linked to chronic diseases), workforce shortages and capacity constraints with the physical ophthalmology estate and digital systems.:

20. It highlighted longstanding, systematic problems in Wales' eye care services. The ophthalmology clinical sector warned that "inaction risks the collapse of eyecare services in Wales", and described the National Clinical Strategy as "the last chance we have to plan a viable future for eyecare in Wales."

21. The Strategy outlines four key strategic themes:

- organisational reform to maximise the workforce;
- establishment of clinical networks to ensure equality of care;
- transformation of patient pathways to improve experience; and
- development of a sustainable delivery model across health board boundaries.

22. The Clinical Implementation Network (CIN) has an annual plan to improve how eye care services are delivered. They report on their progress to a national group led by senior NHS Wales leaders.

23. To drive progress, several Ministerial summits have been held, with the latest in October 2024. Following this, the Welsh Government issued a written statement in December 2024 detailing commitments for health boards and partners. These included implementing and monitoring the Wales General Ophthalmic Services (WGOS) pathways to reduce secondary care demand, adopting integrated care pathways for glaucoma, medical retina, and cataract services and increasing cataract surgery capacity in line with demand.

24. Health boards were also tasked with responding to national and local "Getting it Right First Time" (GiRFT) recommendations, developing high-volume mixed complexity surgery lists, and ensuring accessible patient communications.

25. Additionally, the Clinical Implementation Network was tasked with standardising harm reporting protocols, while the Welsh Government said it would expedite the rollout of an electronic patient record system to enhance care coordination and safety. Workforce needs will be reviewed by Health Education and Improvement Wales (HEIW), and health boards are expected to submit business cases to secure investment for sustainable ophthalmology services, including workforce and estate improvements.

3. NHS waiting times

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

Key Statistics

26. The National Clinical Strategy for Ophthalmology states:

Patient Waiting Lists: More than 1 in 20 people in Wales are waiting for an ophthalmology appointment. Ophthalmology is the single busiest outpatient specialism in the Welsh health service, accounting for 1 in every 8 patients on the NHS Wales waiting list.

Workforce: Wales has just 1.97 consultants per 100,000 population, significantly below the Royal College of Ophthalmologists' recommendation of at least 3 per 100,000.

Projected Demand Growth: Wales experienced a 13% increase in demand in 2023/24 compared to pre-COVID levels. Further, the Royal College of Ophthalmologists has estimated that demand for eye care services in Wales is expected to increase by 40% over the next 20 years.

Evidence from stakeholders

27. Given the seriousness of the current situation and the potential consequences for patients at risk of preventable sight loss, the purpose of our inquiry in this area was to consider what can be done to improve secondary eye care services and reduce the harm caused by delays.

28. We asked witnesses why ophthalmology waiting times remained persistently high, given the recent advancements in integrating primary and community care optometrists into the eye care service model.

29. In their evidence, health boards described problems with rising demand resulting from an aging population, and capacity constraints where post-pandemic backlogs exceed service capacity. They also told us that they faced challenges in balancing priorities, having to manage both high-risk patients and long-waiting patients, often with insufficient capacity for either.

30. Rhianon Reynolds, Llywydd of the Royal College of Ophthalmology, consultant ophthalmologist and clinical lead for ophthalmology in NHS Wales Performance and Improvement, told us there were a number of factors influencing lengthy waiting times, including a lack of prioritisation of the ophthalmology service within health boards; workforce limitations; and clinical space. She also referred to the "historic nature of waiting lists". She said that, whilst ophthalmology is the biggest out-patient specialty in the NHS, "we're often perceived as a small specialty because we don't have in-patients". This, she said, means that ophthalmology was "often not overly prioritised in terms of how we are funded within health boards".[5]

31. She highlighted the problems with short-term funding solutions to tackle ophthalmology waiting lists:

> *"(…) in south-east Wales, we've had funding to outsource a large number of cataract services across the border. So, great, we've managed over the last three months to reach our targets in terms of waiting lists, but that financial investment that's been made in this hasn't actually changed what we do as a core service, so, whilst we may have moved 2,500 patients off the waiting list, we've got no way of actually providing a greater capacity, whereas the £7 million that was given to us by Welsh Government could have been invested in building better infrastructure of estates, employing more staff, doing these things that would have meant that, in two years' time, we're not in the same situation we are in at the moment."*[6]

[5] RoP, 20 March 2025, para 35
[6] RoP, 5 March 2025, para 183

32. She emphasised that any future investment in ophthalmology needed to be a "sustainable investment in NHS services":

> *"You can clear the waiting lists, but unless you do something to stop those waiting lists building up again in a few years' time we're going to be in exactly the same situation we are in at the moment."*[7]

33. Funding constraints and limited resources was also a key theme that came through in the written evidence from health boards. They said there was insufficient recurrent funding to support transformation projects, including training, workforce expansion, and infrastructure upgrades.

34. We discussed waiting times with Dr Andrew Pyott, particularly in relation to cataract surgery. He told us that the different funding model in England meant that over 50 per cent of cataract surgery was being performed by the independent sector. He cautioned that, although this had the effect in some parts of England of making the waiting times for such surgery very low,

> *"in some regions it actually almost amounts to prophylactic cataract surgery, by which I mean that patients are having surgery performed but they don't particularly need it."*

35. He said his concern was that people were being regarded "as a resource to be mined, rather than a patient who actually requires treatment." This, he said, could happen when there was overprovision of service.[8]

36. He told us he was concerned about the long term, destabilising effect that such an approach could have on the NHS in Wales, if it were to be followed. He explained that this approach could be seen as attractive to health boards because they could see large numbers of procedures being performed by independent providers. However, he said that, often, the least complicated cases were assigned to these providers, and their personnel will almost always have been trained by the NHS and then lost from the NHS, in what he described as a "double jeopardy, not least [because] the taxpayer is still paying for all this to be done".[9]

37. The Cabinet Secretary's written evidence notes that there has been "some concern" in the clinical community that prioritising and focusing on an independent sector model for cataract delivery could put local services at risk. He

[7] RoP, 5 March 2025, para 179
[8] RoP, 20 March 2025, para 211 - 213
[9] RoP, 20 March 2025, para 214-215

says this is "not the case, as local services remain an essential delivery mechanism".[10]

38. We questioned a number of local health boards about how they prioritise funding for ophthalmology services compared to other specialties, given the serious consequences of sight loss for individuals.

39. Carol Shillabeer, Chief Executive of Betsi Cadwaladr University Health Board (BCUHB), told us that the health board had a major programme in place in relation to improving planned care, and eye care was a key part of that. She said that eye care was a priority in the health board's integrated medium term plan and that it was an area that the board had oversight of.[11]

40. Andrew Carruthers, Chief Operating Officer, Hywel Dda UHB (HDdUHB), said the health board was aware of the problems facing ophthalmology in west Wales, "as much for workforce reasons as anything else". He said the challenge was not having enough resources to deliver the required level of capacity but that the health board was investing, financially, in eye services.[12]

41. Similarly, Catherine Wood, Director of Operations for Planned Care, Cardiff and Vale University Health Board (CAVUHB), told us that eye care was a priority for the health board, and that it was there was a mismatch between demand and capacity that the health board was working to address.[13]

42. Separately, stakeholders, including William Oliver and Rhianon Reynolds, told us that Ophthalmology should not be treated as a single, uniform specialty, but rather understood and managed at a subspecialty level.

43. William Oliver, Assistant Director, Strategic Programme for Planned Care, NHS Wales Executive, said that ophthalmology was not a "normal surgical pathway", and that patients required ongoing continuation of treatment or maintenance to maintain their sight or potentially prevent irreversible sight loss".[14] This, he said, meant there was a need to have waiting lists on a sub-specialty, granular level so that we can understand the demand/capacity imbalance, rather than just seeing ophthalmology as a global problem".[15]

[10] Written evidence, Welsh Government
[11] RoP, 14 May 2025, para 153-154
[12] RoP, 14 May 2025, para156-157
[13] RoP, 14 May 2025, para 159
[14] RoP, 20 March 2025, para 39
[15] RoP, 20 March 2025, para 39

44. Similarly, Rhianon Reynolds felt that subspecialty-level data and planning could help make the case for more targeted investment and service redesign.

Implementing the national clinical strategy

45. We heard evidence from stakeholders about the need to fully implement the national clinical strategy, and concerns about the speed of progress.

46. RNIB Cymru told us they were "really pleased with the national clinical strategy" and particularly that patient voice and patient support were included within it.[16] However, they were "really concerned" that discussions about the strategy "have gone on for years and years and years".

47. RNIB Cymru drew attention to a written statement published by the Cabinet Secretary for Health and Social Care in December 2024 which, it said, outlined his support for the strategy and his expectations for progress to be made towards its implementation. Although it felt this was a "positive step", RNIB Cymru told us:

> *"To date, there has been no commitment from the Welsh Government to make significant investments needed to implement the recommendations of the National Clinical Strategy.*
>
> *(...) there have been no deadlines put in place and no additional funding allocation to deliver the reforms. It remains unclear who is responsible for coordinating and monitoring the shift to a regional delivery model and whether health boards have dedicated resources responsible for taking this forward."*[17]

48. They told us:

> *"Without this, Wales' eye care waiting lists will continue to rise as will the number of patients who are needlessly losing their sight while waiting for NHS treatment."*[18]

49. Similarly, Rhianon Reynolds told us:

[16] RoP, 20 March 2025, para 470
[17] Written evidence, OP02, and RoP, 20 March 2025, para 470
[18] Written evidence, OP02

> *"We can put the blueprint [the clinical strategy] in place, but without investment in making that change, it's going to be difficult to show significant change."*[19]

50. RNIB Cymru was clear that the Welsh Government "must set clear expectations, including milestones and targets for implementation of the National Clinical Strategy", and that this must be done "at pace" because people are going blind.[20] They also called for NHS Wales Performance and Improvement to be equipped with the "resources and powers it needs to drive operational change".[21]

Integration of primary care optometry services

51. There has been a focus in Wales on organisational reform, specifically integrating primary and community care optometrists into the service delivery model to manage increasing demand.

52. In 2023, the Welsh Government introduced the Wales General Ophthalmic Services (WGOS)[22] as part of new legislation aimed at strengthening primary care optometry's role in eye care. This shift is designed to provide patients with care closer to home and reserve hospital eye services for more critical cases.

53. The new WGOS optometry pathways are intended to reduce pressure on hospital ophthalmology and general practitioners by enabling low-risk patient management and monitoring within primary care. Advanced services include provision of low vision aids, community-based medical retina and glaucoma assessments by highly qualified optometrists, and primary care "eye casualty" services for urgent cases. While advanced WGOS services (WGOS 3-5) are not mandatory for all optometry practices, health boards must ensure their availability within their regions. The Eye Care Wales Committee oversees the implementation of these pathways.

54. In a statement from the Chief Optometric Advisor for Wales published in the Eye Care Digest 2024, David O'Sullivan described 2024 as "a landmark year for eye care in Wales". He emphasised the advancements in the regulatory framework for ophthalmic services:

[19] RoP, 5 March 2025, paragraph 30
[20] Written evidence, OP02, and RoP, 20 March 2025, para 476
[21] Written evidence, OP02
[22] See Annex 2 for details of the WGOS levels

> *"The last 12 months have been transformative, and the journey towards delivering comprehensive, accessible, and high-quality eye care is underway across the whole eye care pathway. We are on the cusp of a new era for optometry in Wales, where optometrists and dispensing opticians are empowered to work at the top of their clinical licence and provide care that is both impactful and rewarding."*[23]

55. We heard from witnesses about the practical benefits of the new WGOS arrangements. Catherine Wood, CAVUHB, told us that the health board had been able to see 65 per cent of high-risk patients within the clinically recommended time frame by being focused on implementing the WGOS 4 pathway. She said:

> *"(…) over the last three months, we've sent out over 1,000 patients to the community, which means that that commensurate shift allows us to free up our secondary care capacity to support the patients that can only be supported in secondary care. I think there is a little bit further we can go to push that service further and send more patients out to community optom".*[24]

56. We also heard that, in addition to getting patients out of hospital, WGOS levels 4 and 5[25] "are the biggest game changers for [preventing] patients entering hospitals". Owain Mealing, Chair of Optometry Wales, told us:

> *"WGOS 5 has shown a reduction in referrals into eye casualty, so these patients are being managed in the community, closer to home. For example, there are constituencies where, if you were to get an eye problem, you'd have to go cross-border previously to be treated, whereas with WGOS 5 you could be managed much closer to home by somebody you know."*[26]

57. Similarly, Dan McGhee, Federation of Optometrists and Dispensing Opticians, told us that the new contract was supporting more practices to offer services that helped to prevent patients from needing to go into hospital. He highlighted the

[23] Chief Optometric Advisor Wales Eye Care Digest, Welsh Government, 2024
[24] RoP, 14 May 2025, para 170
[25] See Annex 2 for details of WGOS levels
[26] RoP, 20 March 2025, paras 323-327

benefits of this for patients in rural areas who might have found it difficult to get to a hospital."[27].

Health inequalities

58. The Pyott Report highlighted the link between low income and sight loss, with 48% of people with sight loss living in households with a total income of less than £300 a week, compared to 19% of people with no sight loss. Additionally, it found people with low vision were more likely to live in more deprived areas. We asked witnesses whether, in redesigning eye care services, enough attention had been given to addressing health inequalities.

59. Owain Mealing told us there was "always more to do" and referred to WGOS 5 and the provision of domiciliary services as an example. He said:

> *"For patients who are in more deprived areas that have difficulty in accessing secondary care traditionally, having a mobile optometrist who can come out and prescribe for their eye condition, or eventually manage their eye condition within their home, is huge. Local access to care with somebody that's familiar is fantastic."*[28]

60. We also asked whether witnesses were satisfied, given the shift of certain eye care services from NHS hospitals to community optometrists, that these services were fully integrated into the NHS funding model to ensure patients do not face additional costs.

61. Owain Mealing confirmed that WGOS 4 and 5, as services that had been moved from secondary to primary care, are "entirely funded by the NHS". He highlighted, however, that "there isn't universal access to routine eye care on the NHS in Wales" and that "there is still an eligibility criteria for certain patients". He said that "everybody gets emergency care, but not necessarily routine care".[29]

62. Dr Pyott referred to the "huge advantage" in Scotland, where sight tests are free of charge.[30]

[27] RoP, 20 March 2025, para 337
[28] RoP, 20 March 2025, para 435
[29] RoP, 20 March 2025, para 443
[30] RoP, 20 March 2025, para 285

Evidence from the Cabinet Secretary

63. In written evidence, the Cabinet Secretary stated that performance management, escalation and accountability falls within the remit of the Welsh Government. He stated that health boards are held to account by the Welsh Government through regular performance meetings, and that performance data is collected and published online monthly, including data about patients waiting for an ophthalmology outpatient appointment and total outpatient appointments attended[31].

64. He noted that, to improve performance and reduce waiting lists and prioritise those at high risk, health boards had implemented various activities including waiting list initiatives, outsourcing patients to third sector or regional providers, obtaining temporary/short-term additional theatre space/capacity, hosting weekend clinics and moving medically fit patients to WGOS optometry pathways.[32]

65. He told us that additional funding to reduce long waiting times in planned care had been issued to health boards in October 2024, and had been used to reduce the number of patients waiting over 104 weeks for treatment. He said that this additional investment is expected to have eliminated all 104 week waits in south Wales, and to have led to significant reductions in north Wales. To continue this improvement, he told us, further investment had been provided to health boards to "deliver additional cataract capacity in Quarter one 2025-26, as part of the planned care plan for 2025-26".[33]

66. He also highlighted that the Welsh Government had placed a number of health boards into escalated status for poor performance as a result of long waiting times for planned care - Betsi Cadwaladr University Health Board, Cwm Taf Morgannwg University Health Board, Hywel Dda University Health Board and Swansea Bay University Health Board.[34]

Lengthy waits

67. 'Integration of primary care optometry' is one of the Welsh Government's four key priorities for ophthalmology.[35] During our evidence session with the Cabinet Secretary, we challenged him on the lengthy ophthalmology waits and, in

[31] Written evidence, Welsh Government
[32] Written evidence, Welsh Government
[33] Written evidence, Welsh Government
[34] Written evidence, Welsh Government
[35] Written evidence, Welsh Government

particular, that only around half of the patients requiring the most urgent eye care are being treated within clinical prioritisation targets.

68. He told us that the focus on changing the delivery of eye care in Wales by reforming the pathway was "starting to bear fruit"[36]. He said the Welsh Government had "increased the value of the contract by about £30 million" recurrently, which he described as a "huge increase", and that funding for primary care was creating capacity in secondary care to bring down waiting lists.[37]

69. He also referred to the eye care summits that he chairs, describing them as a "crucial" opportunity for clinicians and health boards to identify challenges and blockages, track progress, share best practice and follow up on agreed actions.[38]

70. We asked him what he considered to be the main barriers to delivering more consistent, timely treatment. He said that the longest waits had been reduced from "about 8,800 a couple of years ago down to 1,200 now", which was a "very significant reduction".

71. He also said there had been "about an 80 per cent drop in those long waits over the course of the last six months, since October of last year" which, he argued, showed "a very clear link between a national strategy and improved outcomes on the ground"[39].

72. The Cabinet Secretary told us there were three things that needed to be focused on – getting to grips with the backlog; dealing with the level of variation across Wales in terms of performance; and transforming the pathway so that more people can be seen in primary care to free up capacity in secondary care"[40].

73. On the last point, the Cabinet Secretary's written evidence states:

> *"Reform of primary care optometry in Wales is considered the most progressive in the UK.*
>
> *New eye care pathways aim to reduce the number of referrals into secondary care eye services by 30,000 and free up an additional 30,000 ophthalmology appointments by shifting*

[36] RoP, 5 June 2025, para 155
[37] RoP, 5 June 2025, para 156
[38] RoP, 5 June 2025, para 154
[39] RoP, 5 June 2025, para 160, 179
[40] RoP, 5 June 2025, para 161-163

> *services and monitoring low risk patients in optometry primary and community care services."*[41]

74. Alex Slade, Director of primary care, mental health and early years, Wesh Government, confirmed that the current rate was slightly higher – at 36,000 each year.[42]

75. Further, the Cabinet Secretary's written evidence states:

> *"An analysis of the early results demonstrates that, over the first quarter of this calendar year, over 500 glaucoma appointments and over 700 medical retina appointments have been undertaken in primary care optometry practices. As health boards continue to roll out this pathway, these numbers will continue to increase."*[43]

76. We asked the Cabinet Secretary how the Welsh Government was ensuring consistent and equitable access to WGOS services across Wales, and particularly in rural and underserved areas. He told us that health boards were required to establish an oversight body – an eye care committee – to ensure that these pathways were being delivered. This had been done a little over a year ago, and would be reporting on progress against objectives "shortly, and then every three years after that."[44].

77. In relation to sustaining and increasing the capacity of primary care optometry to manage the growing workload, the Cabinet Secretary told us that the "picture for optometry upskilling is really quite remarkable", with some health board areas reporting a twelvefold increase in the higher skilled optometrists in either glaucoma or independent prescribing or the various requirements.[45] He went on to say:

> *"The aim is to make sure that we have two higher trained optometrists in each cluster area. That is the basic—. That's where we're working towards. We've made good progress (…) in medical retina (…) and independent prescribing, and we need*

[41] Written evidence, Welsh Government
[42] RoP, 5 June 2025, para 172, 176
[43] Written evidence, Welsh Government
[44] RoP, 5 June 2025, para 245
[45] RoP, 5 Junen 2025, para 249

to make sure that the same progress is coming through in glaucoma".[46]

National clinical strategy

78. In his written evidence, the Cabinet Secretary stated that the Welsh Government "maintains oversight over ophthalmology strategy implementation, service transformation and performance through specialised eye care monitoring meetings with health boards, and through scheduled deep dives at the health board Integrated Quality Delivery and Performance meetings".

79. He goes on to state that these deep dives and "touchpoints" are used to measure health board progress against Getting It Right First Time (GiRFT) and WGOS actions, actions outlined in the ministerial summit report and the national strategy recommendations.[47]

80. He told us that the 2025-26 national planning guidance sets out a number of expectations for each health board to deliver in relation to ophthalmology, and that progress against these is being tracked through the Planned Care Programme.[48]

81. He accepted that there was "no doubt" that faster implementation of the clinical strategy was essential. He said that NHS Wales Performance and Improvement was working with health boards to identify rapidly their improvement needs. He also told us that the Welsh Government was mandating health boards to implement the standards from the Getting It Right First Time guidelines.[49]

Our view

82. The Welsh Government has identified ophthalmology as one of the seven "exceptionally challenging specialties" due to persistent issues with capacity and demand. Ophthalmology waiting lists in Wales were notably high even before the Covid-19 pandemic, despite the introduction of Eye Care Measures aimed at improving service delivery. The pandemic further worsened the situation by causing widespread disruptions to healthcare services, leading to cancellations and postponements of appointments and treatments. This compounded the

[46] RoP, 5 June 2025, para 251
[47] Written evidence, Welsh Government
[48] Written evidence, Welsh Government
[49] RoP 5 June 2025, para 169

existing backlog, resulting in even longer waiting times and heightened risks of irreversible harm or sight loss for many patients.

83. Despite various actions and initiatives by the Welsh Government and health boards, compliance with clinical prioritisation targets remains persistently low, with only around half of the patients requiring the most urgent eye care being treated within their target. These are patients who are at risk of irreversible harm without timely treatment and yet, as of August 2025, 81,436 patient pathways missed their target date. Further, no health board is currently achieving the national standard of 95% seen within the target timeframe.

84. Organisational reform of primary care optometry is one of the Welsh Government's four key priorities for ophthalmology, aiming to reduce pressure on hospital eyecare services. Work in this area to date has shown impressive results in releasing capacity in secondary care, with over 3000 appointments per month moving across into the community against the Cabinet Secretary's target of creating 30,000 appointments in primary care per full-year cycle. We ask the Cabinet Secretary to update us on progress against this target in due course. Going forward, this will need close monitoring to ensure long-term stability of the primary eye care workforce.

85. This focus on optometry has not, however, been accompanied by a commensurate level of attention on the well-known systemic challenges within ophthalmology, including workforce shortages, lack of digital systems and inefficient patient pathways. We have heard of the deep frustrations felt by the eye care profession about the lack of an electronic patient record and referral system; the unsuitability of the estate for the treatment of visually impaired patients and the ongoing problems with recruiting and retaining staff. We discuss each of these issues in more detail in the later chapters of this report, and make a number of recommendations to the Cabinet Secretary.

86. There remains a significant need for modernisation of secondary eye care to improve patient outcomes and manage increasing demand. While the reform of primary care optometry has delivered tangible benefits – freeing up thousands of secondary care appointments each month – it is disappointing that this achievement is overshadowed by the continued poor performance in secondary care.

87. The clinically-led National Clinical Strategy for Ophthalmology provides the long-term blueprint for this work, with its four strategic elements covering

organisational reform, clinical networks, pathway transformation and a sustainable delivery model.

88. The Cabinet Secretary has been clear that he expects progress to be made with implementing the strategy at pace, and we acknowledge the work undertaken by the Welsh Government in relation to the strategy, particularly the ophthalmology ministerial summits which bring together those responsible for improving outcomes and performance. Additionally, we note the other steps taken by the Welsh Government to address waiting time performance, including placing several health boards into escalated status for poor performance with waiting times for planned care.

89. However, given the critical situation with ophthalmology services and waiting times, we feel that a stronger, more outcome-focused approach is needed to drive the delivery of real and lasting improvements. Most significantly, we believe the Welsh Government must establish a cross-sector oversight board to monitor the implementation of the National Clinical Strategy. The board should have representation from the Royal College for Ophthalmology, health boards, HEIW, DHCW, optometry leaders, and patient groups, and should be responsible for tracking progress against clearly defined milestones, escalating delivery risks and reporting publicly on outcomes.

90. Such an approach would, we believe, be a clear, unequivocal statement of the Welsh Government's commitment to the transformation of ophthalmology services, and would provide a strong, national focus on the delivery of the eye care blueprint. This requires urgent action by the Welsh Government, and must be in place before the Welsh general election next spring.

91. Implementation of the strategy must be accompanied by significant investment, in the same way that significant investment was provided to reform the primary care model. Although the Welsh Government has provided ad-hoc financial support to health boards to reduce waiting lists, these have been short-term interventions which have not enabled long-term, sustainable improvements in services.

92. It is clear that, in order to achieve the end goal of improved patient outcomes, there must be a significant and sustainable investment in secondary eye care services; improving the eye care estate, maximising the workforce and delivering improved services on a regional model. Further, this should support the delivery of services by the NHS, rather than the over-use of the independent sector, particularly for cataract treatment. Without such a commitment by the

Welsh Government, it is hard to see how change of any real significance will be achieved.

Recommendation 1. The Cabinet Secretary should, as a matter of urgency, establish a dedicated, cross-sector oversight board for ophthalmology to monitor the implementation of the National Clinical Strategy. The board should:

- include representatives from the Royal College of Ophthalmologists, health boards, HEIW, DHCW, optometry leaders and patient groups;
- be responsible for tracking progress with implementation against clearly defined milestones; escalating risks with delivery; and reporting publicly on outcomes;
- be established prior to the Welsh general election in 2026.

Recommendation 2. The Cabinet Secretary should, in February 2026, update the Committee on progress with implementation of the National Clinical Strategy, including:

- details of any agreed key milestones, and progress with their implementation (including who has responsibility for their delivery);
- any risks identified with delivery of those key milestones.

Recommendation 3. The Welsh Government must commit to a programme of investment specifically for secondary ophthalmology services which mirrors the scale and sustainability of the investment made in primary care optometry. This programme should cover estate and accessibility improvements, equipment replacement cycles and workforce expansion and retention initiatives.

Recommendation 4. The Cabinet Secretary should, in February 2026, update the Committee on progress against the Welsh Government's target of creating 30,000 primary eye care appointments per full-year cycle and demonstrate how secondary care reforms are being aligned with WGOS success.

93. More specifically, and as regards data about waiting lists, a recurring theme in the written and oral evidence was the need to understand and manage ophthalmology at a sub-specialty level, rather than treating it as a single, uniform specialty.

94. There is a need to better understand ophthalmology waiting lists, with current waiting list data lacking the granularity needed to inform effective service

planning. A subspecialty-level analysis is essential to identify where capacity gaps exist, for example within retina, glaucoma, paediatrics. Such an approach would, we believe support smarter resource allocation and help to reduce patient harm.

Recommendation 5. The Cabinet Secretary should commit to ensuring that waiting list data for ophthalmology is captured at a sub-specialty level to inform effective service planning, support smarter resource allocation and help to reduce patient harm.

4. The patient experience

> *"I'm likely to be condemned to lose my sight by inaction [by the NHS]. I feel that time is indeed [of] the essence for my sight and retaining it."*
>
> *Edward Kenna, 80, patient with macular degeneration*

95. As part of our inquiry, we heard directly from patients about the impact of prolonged waiting times on their health, their livelihoods and their quality of life.

96. We heard from Edward Kenna, who has macular degeneration. He told us that the drug being used in his treatment had not been administered at the correct intervals, despite him raising his concerns about this with the hospital. He said:

> *"Each time I have been tested by the hospital after the 16-week maximum norm, it has led me to require emergency treatment."*[50]

97. He told us that he subsequently noticed a "big, black football, black circle in my eyesight", and was told by a doctor at the hospital that this was a floater. However,

> *"when I spoke to my optician about it, he said, 'That's not a floater.' He said, 'That's macular damage.' He actually showed me a magnified picture of the macula and I could see the damage. (…) So, that's with me all the time now."*[51]

98. He told us that, whilst he was "grateful" for the treatment he was receiving, he felt that the hospital was not listening to him, or to other patients:

> *"I also feel very angry and let down by the NHS. I do not believe the hospital that treats me (…) as they've failed to listen to me. I tell them, but it just doesn't work. 'Listen to the patient; listen to me as a patient'".*[52]

99. Marian Williams from the Macular Society described the lack of support for patients who are required to travel long distances for treatment. She said that the

[50] RoP, 20 March 2025, para 522
[51] RoP, 20 March 2025, para 527
[52] RoP, 20 March 2025, para 517

rurality of Wales meant that some patients had to travel up to 100 miles for injections, with little support for transport. She also said that, whilst some hospitals were offering treatments on weekends to reduce waiting times, a lack of public transport in parts of Wales on the weekend meant that patients had difficulty getting to those appointments:

> *"One gentleman I know has been waiting over 20 weeks for his injections and was offered treatment at another health board, where he had to travel 150 miles with no offer of support. Luckily for him, he had a family member, and that family member was able to take time off from his employment to take him. Otherwise, he would have lost that appointment and potentially lose some of his valuable sight."*[53]

100. We heard from patients about the impact of prolonged waiting times on their ability to work, and about the lack of communication about the expected timelines. Sara Crowley, BNIB Cymru and a eyecare patient, told us:

> *"When I was waiting for my operations, and waiting for laser, I lost my job. I lost my job not because I couldn't see to do my job well, but I lost it on the basis of discrimination against somebody who was going through sight loss and waiting for treatment. I couldn't give them a timeline, and I got heavily discriminated against.*
>
> *So, I got sacked, and I took them to a tribunal. (…) I couldn't claim benefits because I was deemed fit to work, but I lost the tribunal, based on the fact that I was deemed fit to work."*[54]

101. We also heard about the need for greater emotional and practical support for patients throughout the care pathway. Sara Crowley told us that, after losing her job:

> *"I thought my life was over.*
>
> *And I remember sitting, heavily depressed, in my parents' room because I'd had to move back home with them (…)*
>
> *I really feared where I would go, not having support. I never thought I'd be employed again, and there was nowhere outside*

[53] RoP, 20 March 2025, para 561
[54] RoP, 20 March 2025, paras 538-539

> *of eye services to be able to catch me, and, if there was, I couldn't access them and I couldn't find them."*[55]

102. Lowri Bartrum from Vision Support also called for greater emotional and practical support for patients, and told us about a young, single mother who had accessed their services:

> *"She was diagnosed with quite a rare eye condition, and the ophthalmologist was scrolling through what he'd found on Google in front of her. He then said, 'Yes, there's nothing that we can do for you. I'm going to discharge you. You're going to go blind.' She then left. She went and sat in the waiting room in the hospital. She was told that she was distressing other people in the waiting room, so she was asked to leave the waiting room. Because she's estranged from her family and quite isolated, she phoned her health visitor because her son was still under five.*
>
> *She contacted her health visitor and was just panicking, saying, 'I've just been told I'm going to go blind, I don't know what I'm going to do. I don't know how I'm going to keep my son safe', and all of these different things. And she was just basically spiralling.*
>
> *At that point, the health visitor contacted social services and then social services arrived at her front door saying, 'We believe that there's a child at risk at your property.' So, literally everything that could go wrong in that diagnosis process did go wrong. There was no point at which she was offered any support, either emotional or information or advice about where to go to. She eventually found us a number of months later on. So, she went through all of that process on her own."*[56]

103. Throughout their testimonies, individuals were clear about the need for the patient voice and experience to inform all aspects of service and delivery. Sara Crowley told us:

[55] RoP, 20 March 2025, paragraphs 538-539
[56] RoP, 20 March 2025, para 546-547

> *"I'm not entirely sure what the answers are, but I would very much involve patients and those with lived experience in this, and I think they have a part to play as well."*[57]

Eye care support pathway

104. Ansley Workman, RNIB Cymru, highlighted the 'eye care support pathway', which she said had been developed a number of years ago by the eye care sector across the UK, the royal colleges and patients. She told us that the pathway "recognised all of the pin points, so pre diagnosis right through to post diagnosis", and had been accepted within the national clinical strategy. She said:

> *"So, what we need now is to make that happen, and that is about ensuring that, at every point of your pathway for eye care, you are offered advice, information and support. We are working with the CIN on that, but again it's something that needs to happen quickly so that people have got support".*[58]

105. Lowri Bartrum, Vision Support, was positive about the establishment of the eyecare support pathway, but said it was "absolutely essential" that the pathway was embedded within the clinical space to ensure referrals into the third sector to provide ongoing support for people.[59]

106. She also highlighted the "fundamental" role played by eyecare liaison officers in providing advice and support to individuals."[60]. Similar point were made by Ansley Workman, Director of RNIB Cymru. She also told us that arrangements varied across health boards:

> *"some health boards provide some funding and fund them themselves, but in many health boards, every year, you're renegotiating a contract, so it's year-on-year in some health boards, and the third sector provides that ECLO support. So, our view is that the workforce should include the ECLOs within that workforce planning so that you've got that bridge between health and social care".*[61]

[57] RoP, 20 March 2025, para 541
[58] RoP, 20 March 2025, para 543
[59] RoP, 20 March 2025, para 555
[60] RoP, 20 March 2025, para 554
[61] RoP. 220 March 2025, para 559

Patient harm

107. We heard worrying evidence from RNIB Cymru about the "considerable disparity between the number of people waiting beyond their target date and the number that are reported as having suffered harm as a result".[62]

108. RNIB Cymru stated that a Freedom of Information Request to Public Health Wales in 2023 had revealed that between June 2021 (when 64,790 patient pathways were beyond their target date) and September 2023 (when the figure was 77,230 patient pathways) only 45 patient safety incidents were reported across Wales relating to ophthalmic services.[63]

109. RNIB Cymru stated:

> *"This is almost certainly a significant underreporting of the scale of harm befalling patients and clearly shows that the system is not working.*
>
> *It is critically important that services accurately quantify the numbers of patients who have lost sight as a consequence of delayed treatment. If incidents of harm are not reported then they are not investigated, remedial action is not taken, improvements are not identified, and learning is not embedded to prevent similar incidents occurring in the future."*[64]

110. Further, it argued that inaccurate reporting of patient harm would mean that decision makers, including Health Board leaders, NHS Wales Performance and Improvement and the Welsh Government, would have no insight into the scale of the real harm being experienced by eye care patients, and would therefore be unable to make fully informed decisions about where to focus resource and attention to improve patient safety.[65]

111. RNIB Cymru called on the Welsh Government to "improve the accurate reporting of the harm caused by delays to diagnosis and treatment so that eye care is afforded appropriate priority alongside other long-term chronic conditions."[66]. They told us that appropriate training was needed to ensure proper

[62] Written evidence, OP02
[63] Written evidence, OP02
[64] Written evidence, OP02
[65] Written evidence, OP02
[66] Written evidence, OP02

reporting of harm, and there needed to be monitoring to ensure that health boards were reporting as they should.[67]

112. Rhianon Reynolds, Llywydd of the Royal College of Ophthalmology, consultant ophthalmologist and clinical lead for ophthalmology in NHS Wales Performance and Improvement, told us that the RCOphth was "fully aware" of the issue of underreporting of patent harm. She said:

> *"Severe harm within ophthalmology is vision loss; it's rarely death. Where there is difficulty, I think, is with interpretation of those within health boards. The process of reporting harm is arduous, difficult and time-consuming. It's often reviewed by people who don't understand ophthalmology, and often patients coming to harm are downgraded in terms of harm when it reaches levels who don't understand ophthalmology.*
>
> *(…) until we make those processes easier, and until there is proper recognition of what harm actually is in eye care, I think we're going to struggle to realise the true indicators of harm."*[68]

113. William Oliver, Assistant Director, Strategic Programme for Planned Care, NHS Wales Executive, told us that health boards had started to use royal college definitions and guidance about patient harm both to learn lessons and to try to avoid prospective harm. He said he hoped to see that approach taken forward by all health boards.[69]

114. We questioned a number of local health boards on their procedures for reporting patient harm and whether they were generally aware of underreporting of patient harm. The three health boards we heard from told us that they were focused on patient harm and trying to improve their own arrangements. Carol Shillabeer told us that BCUHB was moving increasingly "from the reactive response to the proactive response", seeking to find cases of patient harm rather than waiting for them to identify themselves in the form of complaints or clinical negligence claims."[70].

[67] RoP, 20 March 2025, para 510
[68] RoP, 20 March 2025, para 18
[69] RoP, 20 March 2025, para 19
[70] RoP, 14 May 2025, para 182

115. Andrew Carruthers, Chief Operating Officer, Hywel Dda UHB, made similar points, telling us that the health board was aware of the likely under-reporting of harm and trying to be more proactive in identifying cases at an earlier point.[71]

116. Similarly, Catherine Wood, Director of Operations for Planned Care, CAVUHB told us that "the review and reporting and escalation of harm is an absolute priority" for the health board. They also recognised a likely underreporting of harm and "have proactively sought to do something about that in terms of employing a dedicated harm-review team. Their sole function is working through these patients, detail and learning, to see what we can do differently in the future."[72].

117. In relation to optometry, we heard from NHS Wales Shared Services Partnership (NHSWSSP) that they routinely collect patient-reported experience measures across WGOS 1, 2 and 3, and intended to introduce that into WGOS 4 and 5 as soon as they are able. NHSWSSP told us:

> *"what we are trying to do is to improve services for patients, and in doing that, make sure that the experience they have in accessing our services is as good as it can be. So, we are trying to bring the patient voice, the patient representative, into what we do."*[73]

Patient voice

118. We asked witnesses whether they felt that the patient voice was helping to identify both problems within ophthalmology and also areas for improvement to reduce waiting times. Owen Williams, Director of Wales Council for the Blind and a patient at Cardiff and Vale UHB, told us they had good examples of where this had happened, and where the patient voice had contributed directly to the improvement of services, but that more still needed to be done.[74]

119. He pointed to the work of the Wales vision forum, which comprises of local, regional and national sight loss charities:

> *"(...) we have representatives that sit on each of the eye care collaboration groups, and it is our role to make sure that that patient voice is represented and shared to the sector. We would like to see the patient voice high up on each of the agendas,*

[71] RoP, 14 May 2025, para 185-186
[72] RoP, 14 May 2025, para 195
[73] RoP, 5 June 2025, para 28
[74] RoP, 20 March 2025, para 492

and we meet regularly as a sector to ensure that that voice is channelled through."[75]

Evidence from the Cabinet Secretary

120. We challenged the Cabinet Secretary on underreporting of patient harm, and asked him what more could be done to ensure that health boards followed the guidelines set by the Royal College.

121. He accepted there was likely to be underreporting of patient harm currently, and stated that the Welsh Government "remains concerned" about the impact of extended waiting times on a patient's clinical condition".[76] He said, however, that the situation was improving partly because of a number of steps which were being taken.

122. He stated that he had instructed the Clinical Implementation Network for ophthalmology to develop and implement a standardised harm reporting protocol across all health boards based on guidelines set by the Royal College of Ophthalmologists".[77]

123. He also told us that reporting of patient harm was a matter included as part of Welsh Government accountability meetings with health boards, which provided an opportunity to "test, challenge and provide support" to health boards."[78].

Our view

124. We heard really powerful evidence from patients about the impact of delayed treatment on their quality of life, and the fear they have of losing their sight.

125. Long waiting times for treatment have emotional and practical consequences. They can lead to the loss of independence, including the ability to drive, read, or recognise faces which, in turn, can lead to social isolation and mental health challenges. They can also have an impact on a patient's employment, with some people having to give up work altogether as their eyesight deteriorates.

[75] ROP, 20 March 2025, para 494
[76] Written evidence, Welsh Government
[77] Written evidence, Welsh Government, and RoP, 5 June 2025, para 190
[78] RoP, 5 June 2025, para 189

126. Patients often feel uninformed about their condition, their treatment options and the expected timelines. They need clearer communication from health boards and clinicians, as well as more consistent emotional and practical support throughout the care pathway.

Recommendation 6. The Welsh Government and NHS Wales should ensure that patient experience and support are embedded throughout the ophthalmology care pathway. This should include:

- full implementation of the eye care support pathway, ensuring patients receive timely information and emotional support at every stage of their care journey;
- a review of the likely benefits of including eye care liaison officers in workforce planning in order to ensure sustainable funding and consistent provision across all health boards;
- strengthening the role of the patient voice in service design, monitoring and evaluation, including representation on regional eye care boards and clinical networks;
- ensuring equitable access to services, particularly for patients in rural and underserved areas.

Patient harm

127. There is an awareness, both within Welsh Government and within health boards, about the likely underreporting of patient harm caused by delays to diagnosis and treatment in ophthalmology.

128. Inaccurate reporting of harm carries with it significant implications for patients, with incidents not properly investigated and appropriate remedial action unable to be taken fully. It also limits the opportunities for wider learning, and does not provide an accurate picture of where resources should be appropriately focused to improve patient outcomes.

129. As this is an area that needs to see real improvements, we were pleased to hear that the Welsh Government has instructed the development and implementation of a standardised harm reporting protocol across all health boards. We support this measure, and believe it should be implemented at pace. We believe that implementation should be accompanied by provision of appropriate training for health board staff to ensure incidents of harm are

captured and reported correctly. Further, that robust monitoring arrangements should be in place to ensure that the protocol is being followed and harm incidents properly reported by all health boards.

Recommendation 7. The Cabinet Secretary should, by the end of February 2026, update us on progress with the development and implementation of a standardised harm reporting protocol across all health boards, including details of any targets and milestones. As part of this, he should:

- confirm that appropriate training will be provided for health board staff to ensure the accurate capture of harm incidents, and
- provide details of the monitoring arrangements he intends to put in place to ensure that, once implemented, the protocol, is being followed by all health boards.

5. Digital and technological barriers

In 2021, Wales launched its first **national digital eye care electronic patient record and referral system**, investing over £8.5 million in the 'Open Eyes' platform, led by Cardiff and Vale University Health Board.

The National Clinical Strategy for Ophthalmology states that the delivery of an **ophthalmic electronic patient record** is "an urgent priority".

The Strategy states:

"Digitalisation of eye care is fundamental to the delivery of transformational eye care service. Wales is behind the other UK nations with no fully functioning Electronic Patient Record (EPR) in any unit in Wales."

As regards **digital referral**, the Strategy states:

"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 (primary care eye services) and HES (hospital eye services).

"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."[79]

Evidence from stakeholders

130. We heard a number of serious concerns from respondents about the challenges in ophthalmology services as a result of digital and technological barriers. These concerns centred around three main issues:

- an electronic patient record,
- an electronic patient referral system, and
- the interoperability of digital systems.

131. RNIB Cymru stated that the electronic patient record and referral system for Wales was intended to give hospital ophthalmologists and community

[79] National Clinical Strategy for Ophthalmology, *Delivering the Future of Ophthalmology in Wales*, September 2024

optometrists access to shared clinical information to monitor eye health and provide shared care. It said:

> *"Four years later, the system is still not operational in any health boards in Wales and does not fulfil most of the core functions it was intended to."*[80]

132. RNIB Cymru told us that, to date, there has been no public Ministerial commitment to commission a digital strategy for ophthalmology and there is no roadmap in place for the implementation of EPR.[81]

133. RCOphth, Optometry Wales and the College of Optometrists all raised similar concerns. The RCOphth highlighted its 2024 survey of clinical leads, which found that:

> *"no ophthalmology department in Wales had a well-functioning electronic patient record (EPR) system, interoperable patient records with optometry, nor an electronic eye care referral system."*[82]

134. The College of Optometrists stated that "digital/IT connectivity is a key enabler to transform eye care service delivery" but that:

> *"a major barrier to achieving [improved patient outcomes and experience] is a lack of an effective digital solution for eye care in Wales that continues to limit the transformation of services and the potential of WGOS reforms."*[83]

135. It told us that many optometrists were unable to access electronic patient records and could not digitally refer patients to their local hospital eye service. This, they said, prevented optometrists and ophthalmologists from working together better and improving patient outcomes.[84]

136. The College of Optometrists also stated that many digital images cannot be shared between optical practices and the local hospital eye service, meaning that patients must have the same images taken again at the hospital after referral.

[80] Written evidence, OP02
[81] Written evidence, OP02
[82] Written evidence, OP01
[83] Written evidence OP04
[84] Written evidence, OP04

They told us that this lengthened delays in diagnosis and treatment, and increased unnecessary costs for the NHS in Wales.[85]

137. Optometry Wales described its Board as being "frustrated" with the delays in both the electronic patient record and eye care referral systems, saying that the lack of these digital solutions was "adding an administrative burden to both optometry and ophthalmology" and was "hindering health boards in discharging patients to optometry as a paper exercise is required rather than optometry being able to access a patient digital record".[86]

138. Similarly, Health Boards also highlighted digital challenges in their respective evidence, stating that the absence of a functioning EPR system and interoperable digital platforms hampers efficiency and integration across primary and secondary care. In addition, they told us that delayed Implementation of digital solutions, such as referral systems and EPR, had been slow, affecting service transformation.

139. Dr Andrew Pyott told us that an electronic record was becoming "utterly essential in modern healthcare"[87]. He said that, in Scotland, driving out the provision of the OpenEyes digital patient record to every health board was seen as a "national policy, a very necessary national directive that needs to be followed".[88] He particularly highlighted the benefits of an EPR for the provision of treatment in more remote, harder-to-reach areas, which tended to be underprovided with ophthalmologists.[89]

140. He also told us that patient referral was also "all electronic" in Scotland, with optometrists having been given an NHS e-mail account to ensure no concerns about breaches of patient confidentiality.[90] On this point, Owain Mealing, Chair of Optometry Wales, said that the "biggest change" for optometrists in Wales had been "having access to NHS emails as of last year", and that this was "going to make a big difference".[91]

141. Overall, respondents felt that the roll-out of an ophthalmology-specific national electronic patient record and referral system, accessible in both primary eye care services and hospital eye services, was "essential and long overdue"[92].

[85] Written evidence, OP04
[86] Written evidence, OP03
[87] RoP, 220 March 2025, para 296
[88] RoP, March 2025, para 239
[89] RoP, 220 March 2025, para 297
[90] RoP, 220 March 2025, para 289
[91] RoP, 5 March 2025, para 364
[92] Written evidence, OP01

They told us that this would require investment and leadership from the Welsh Government to facilitate Digital Health and Care Wales (DHCW) and heath boards in implementing the ophthalmology EPR at pace.[93]

142. In relation to the interoperability of digital systems, the College of Optometrists said there were several digital systems currently available to take and review ophthalmic clinical images within hospital trusts and optical practices. However, the "historical lack of agreed interoperability standards means most of these systems and image files are incompatible with one another".

143. The College of Optometrists told us that it was co-leading a digital imaging Task and Finish group with the RCOphth to develop a set of 'Digital Imaging and Communications in Medicine' standards that will drive interoperability of digital ophthalmic imaging systems. It said that the adoption of digital image sharing standards by Health Boards and trusts, healthcare professionals and primary care practice owners would support better image sharing.[94]

144. Owain Mealing told us:

> *"Connectivity, rather than integration, I think, is what we're looking for, where all the systems work without needing new systems, many new systems."*[95]

145. Sara Crowley, RNIB Cymru, told us it was "vital that systems and different conditions can speak to each other:

> *"You have to have systems that speak to each other, so that the right people have the correct information, and that there's not a lot of repeating your story.*
>
> *"We have to look to see how everybody can have digital systems that speak to each other. I think patients want their data to be shared, because, ultimately, they want the best treatment available."*[96]

[93] Written evidence, OP01, OP02, OP04
[94] Written evidence, OP03
[95] RoP, 20 March 2025, para 407
[96] RoP, 20 March 2025, para 569

National Digital Eyecare Programme

146. Launched in 2020, the National Digital Eye Care Programme is a Welsh Government sponsored programme of work to digitise the Ophthalmology Electronic Patient Record (EPR) and Referral processes across NHS Wales.

147. Until June 2023, the National programme had been managed and delivered by CAVUHB on behalf of the Welsh Government, all Welsh Local Health Boards and Primary Care Optometrists. The Programme formally transferred to DHCW on the 1st June 2023.

148. Initial funding comprised £4.8 million capital funding from Welsh Government and a revenue contribution by health boards of £3.7m. The expectation was that health boards were expected to have finished setting up the systems by the end of March 2023. However, the project has faced significant delays, with only a partial deployment. In its written evidence, DHCW states that in March 2023, Welsh Government flagged the programme as Amber/Red, recognising that 'successful delivery of the programme is in doubt with major risks or issues apparent in a number of key areas'.

149. By June 2023, the 'OpenEyes' EPR system had been deployed in ten ophthalmology subspecialties within CAVUHB and one additional ophthalmic setting in Cwm Taf Morgannwg University Health Board. At that point, £4.02 million of the £4.8 million budget from Welsh Government had been spent.

150. DHCW's written evidence sets out that, on 1 June 2023, five health boards had not implemented the EPR system. Further, the electronic referral system (ERS) had not been piloted or implemented at all. Subsequently, the programme, along with the remaining funds, was transferred to DHCW for further management, with CAVUHB continuing to host the technology (as they remain the contracting authority).

151. Following a pause in the programme by DHCW to reassess the scope, timeline and resources for the project, DHCW stated that they submitted a Digital Investment Proposal to the Welsh Government in January 2024. Their preferred approach combined two approaches at the same time: new competitive procurement (to look for new suppliers to get the best deal for new systems), with 'tactical deployment' under existing arrangements.

152. The Welsh Government rejected the initial digital investment proposal because the timelines were too long and some deployment plans and costs were missing. The tactical deployment plans showed that implementation would take

between 8 months to 2.5 years. Financial and delivery plans were presented, but health boards could not commit without confirmed funding. The estimated costs for implementing electronic referrals are £4 million over 7 years, and £1 million for the EPR.

153. During our oral evidence session with DHCW and CAVUHB (Digital and Health Intelligence), we asked them about the current status of the OpenEyes project. David Thomas, Director of Digital and Health Intelligence at CAVUHB, confirmed that the EPR had been deployed across all ophthalmology sub-specialties in CAVUHB".[97] He went on to say that it was being rolled out to all other health boards across Wales, "starting in the south-east region". He told us:

> *"the expectation that we are working to is that OpenEyes as an EPR will be implemented across all the health boards during this current financial year. What we haven't agreed with individual health boards is whether that will include all specialties by the end of March. So, they're the discussions we need to have with each health board, but the intention is to roll it out during this year."*[98]

154. In relation to the electronic patient referral system, Helen Thomas, Chief Executive of DHCW, told us there had been some pilot work in Cardiff as part of the eye care programme. She said this work was part of a strategic recommendation made by DHCW that would "require circa £2 million additional investment over a seven-year period".[99]

155. We challenged DHCW and CAVUHB about why there had been such a delay with the rollout of the EPR and electronic patient referral system. David Thomas told us that the launch of the programme coincided with the pandemic, "so there was obviously an impact there". He said that, whilst the programme specification was generally understood. "the mechanism by which that was to be deployed was not necessarily understood by every health board". He went on to say:

> *"I think that there is something around the clarity and the engagement, to ensure that everybody was on the same page in terms of what was being proposed, and I think that, probably*

[97] RoP, 14 May 2025, para 10
[98] RoP, 14 May 2025, para 140
[99] RoP, 14 May 2025, para 112

> *in hindsight and in terms of lessons learned, the engagement could have worked a lot better with other health boards".*[100]

156. In relation to the financial investment that accompanied the original programme, David Thomas confirmed that the money invested by the Welsh Government was by way of capital which "covered the kits that ophthalmology required within the health boards".

157. He said that the remainder of the money "was health boards investing themselves into the programme, and clearly that hasn't happened in the way that was envisaged at the outset, partly because the other health boards hadn't seen the benefit and weren't realising the benefit in terms of the money that they were being asked to contribute"[101].

158. Given this evidence, we asked whether the delay had been as a result of health boards not having fully committed to the new system and the overall vision for digital services. David Thomas told us:

> *"I think the way that the programme was implemented and managed in the early days, there were a number of concerns that some of the health boards had. There were a number of issues in terms of how things would work; particularly, there were concerns from a cyber perspective, there were concerns about the change management processes, and it did take some time for those things to be resolved.*
>
> *I think we've now been able to re-engage with all the health boards and everybody's absolutely clear on what the plan is, what the expectation is, and what the benefits are that can be realised."*

159. We challenged the health boards on this evidence, and asked them whether the delay in the rollout of the digital solution was a result of health boards not having fully committed to the OpenEyes solution.

160. Carol Shillabeer, Chief Executive of BCUHB, told us that the health board was "really keen on digital solutions" and that the commitment from the board was "high in terms of digital solutions" because they add significant benefit to clinicians and support care across the region.[102] She said that, in terms of

[100] RoP, 14 May 2025, para 44
[101] RoP, 14 May 2025, para 45
[102] RoP, 14 May 2025, para 217-218

OpenEyes, the health board had done some early preparatory work and had put an interim arrangement in place in the meantime. She said the health boards would be "restarting that active preparation with the intention that (…) we are ready to take this as soon as we possibly can. We know that it's a big enabler for care across the pathway, so it is a priority for us in our specialty plan for this year."[103].

161. Andrew Carruthers, Chief Operating Officer, HDdUHB, said that his health board was "very much committed to the need for an electronic referral pathway and patient record" and that, within its regional eyecare programme board with Swansea Bay UHB, "one of our key deliverables for this year is to progress towards the introduction and implementation of OpenEyes through the course of the next 12 months".[104]

162. David Thomas told us that, in recognition of the financial constraints facing all health boards, "there was a request [to the Welsh Government] that there be some additional funding made available to health boards in order to cover the local implementation costs"[105]. He confirmed that around £50,000 had been made available per health board to "boost the implementation resource that will be needed for each health board to go live".

163. Looking ahead to the wider roll-out of the EPR system to the remaining health boards, Helen Thomas told us that "capacity is a real challenge for the health boards, and investment is a real challenge, given the current financial context as well". She said the future roll out would require "really clear prioritisation [by health boards] and it requires pragmatism and collaborative working (…) and learning from each other".[106]

164. However, she went on to say that she believed there was a consensus in health boards, and that "seeing the successful roll-out now in Cardiff goes a long way to alleviating, maybe, some of the concerns around the change and the impact of that change".[107]

165. David Thomas agreed, saying:

> *"I think it's making sure that the health boards prioritise this as an urgent programme of work, really. I think the clinicians have*

[103] RoP, 14 May 2025, para 220-222
[104] RoP, 14 May 2025, para 227
[105] RoP, 14 May 2025, para 56
[106] RoP, 14 May 2025, para 87
[107] RoP, 14 May 2025, para 77

made the case, and it's making sure that it lands with the right people in each of the health boards".[108]

Evidence from the Cabinet Secretary

166. "Digital transformation" is one of the Welsh Government's four key priorities for ophthalmology.[109]

167. We asked the Cabinet Secretary why the electronic patient record and referral system had not yet been rolled out nationally, given its importance. He said there had been "challenges in the development and design of the programme" and that when the Welsh Government became aware of those challenges, "we acted quite quickly to step in and review the governance, the budget available, and the details about how it was being developed".[110]

168. He told us that, following a review of progress by NHS Wales internal audit, the project was placed in the hands of DHCW, a "reset" then took place and "we have a plan now".[111]

169. He told us that the electronic patient record system was the subject of a Welsh Government commitment to "expedite" its implementation[112] and had, he said, "developed well".[113]

170. In relation to the electronic patient referral system, he said this has "not been as effective" and, as a result of working with DHCW, "we've agreed on a way of moving this forward now". He confirmed this would not involve developing a new system, but instead purchasing a commercially available programme for the health service. He said he was "confident that that will allow the programme to be rolled out in every health board by the end of this [financial] year, so by March of next year".[114]

[108] RoP, 14 May 2025, para 136
[109] Written evidence, Welsh Government
[110] RoP, 5 June 2025, para 204
[111] RoP, 5 June 2025, para 204
[112] In a written statement on 20 December 2024, the Welsh Government published a report following the previous ministerial summit, which included a commitment and action for the Welsh Government to expedite the implementation of the electronic patient record (EPR) system to improve communication and efficiency between primary and secondary care and improve patient safety.
[113] RoP, 5 June 2025, para 205
[114] RoP, 5 June 2025, para 205

171. The Cabinet Secretary also confirmed that funding to support health boards to roll out the open eye platform and prepare for electronic referral had been identified as part of the Digital Programme Investment Fund (DPIF) for 2025-26.

172. We challenged the Cabinet Secretary on the role of DHCW in the programme, and their escalation to level 3 for major programme performance. He said:

> *"Clearly, we have challenges in the way DHCW develops these major programmes. I think, in this case, the fairest analysis is to say that there are challenges in every part of the system, and that it's just not at the door of DHCW, to be fair".*[115]

173. He did not accept that there had been a lack of leadership by the Welsh Government in the delivery of the digital programmes, saying:

> *"the history of this hasn't been a success story because of the delay. But there hasn't been a lack of leadership. We've stepped in, the referrals have happened, and there is money behind that and action at the grass-roots level to ensure that it will be available by next March".*[116]

Our view

174. A well-functioning digital record and referral system is essential in the delivery of improved patient outcomes in ophthalmology. Wales is lagging behind the other UK nations in this regard.

175. Despite the launch of the National Digital Eye Care Electronic Patient Record and Referral System in 2021, accompanied by significant funding from Welsh Government, this has yet to be implemented in the majority of health boards, with some making their own, interim arrangements in the meantime.

176. The lengthy delays in the procurement and implementation of both the electronic patient record and the electronic patient referral system have caused deep frustration for clinicians and contributed to delays in diagnosis and treatments, which may have impacted patient outcomes.

177. Whilst we acknowledge that the Covid-19 pandemic was a factor, it is unacceptable that such significant delays in the delivery of such a fundamental

[115] RoP, 5 June 2025, para 207
[116] RoP, 5 June 2025, para 209

resource were allowed to continue for so long and that, nearly 5 years after its launch, this critical project has still not been fully delivered. Whilst the Welsh Government has now intervened in an effort to hasten implementation, earlier intervention could have led to earlier improved outcomes for patients. Until a unified digital system is delivered fully across all health boards, there will inevitably be real and significant limitations on the transformation that can be achieved in the delivery of eye care services in Wales.

178. Health boards and the Welsh Government have heard the strong, repeated views of clinicians and the third sector about the overwhelming need for an electronic patient record and referral system that supports both primary and secondary care. They have now seen the benefits of such a system operating in practice in one health board area, where improved connectivity between community optometrists and hospital eye care services has helped streamline care and reduce delays. The Welsh Government also provided additional funding to health boards to support the implementation of the new digital system.

179. The remaining health boards must now prioritise and commit fully to implementing the electronic patient record and referral system in their respective areas, and must put in place the necessary resources to do this, both in terms of finance and personnel. This must include a commitment to engage and work together with DHCW and CAVUHB, as well as a commitment to collaborative working and shared learning with the other health boards.

180. For its part, the Welsh Government must take the necessary steps to assure itself about health boards' commitment in this area. It must also monitor closely the progress made by DHCW and health boards in implementing the OpenEyes system. The Cabinet Secretary has told us that this system will be rolled out across all health boards by March 2026. We intend to monitor this commitment.

181. As regards the much needed electronic patient referral system, the Cabinet Secretary has committed to the implementation of a commercially available programme in every health board by March 2026. Again, we intend to monitor progress against this target.

Recommendation 8. In his response to this report, the Cabinet Secretary should provide an update on progress with the implementation of the OpenEyes digital system against the March 2026 target. Specifically this update should include details of:

- the health boards where the system has been fully implemented across all subspecialities;
- the health boards where implementation is in progress but not completed (and details of the completed and outstanding subspecialities), and
- the health boards where implementation has yet to begin.

Recommendation 9. The Cabinet Secretary should make an oral statement in March 2026 about implementation of the OpenEyes digital system. This statement should:

- confirm clearly whether the March 2026 deadline has been met and the OpenEyes digital electronic patient record has been fully implemented across all health boards and subspecialties, in line with the Welsh Government's target;
- provide a full explanation for any delay in meeting this target, including revised timelines and actions being take to address outstanding implementation, and include a breakdown of implementation by health board and subspecialty.
- provide an update on progress with the implementation of the electronic patient referral system in all health boards.

6. Regional delivery of ophthalmology services

> *"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.*
>
> *Whilst there are small aspects of regional working underway in Wales there needs to be wholesale overhaul of the behaviour of health boards 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."*
>
> *National Clinical Strategy for Ophthalmology*

Evidence from stakeholders

182. Stakeholders, including RNIB Cymru and RCOphth, emphasised the importance of regional working in the future delivery of ophthalmology services in Wales, describing the regional working model as "essential".[117]

183. RNIB Cymru referred to the key recommendations in the National Clinical Strategy for Ophthalmology which, it said, called for a "fundamental redesign of the delivery model of eye care centred around three purpose-built regional centres of excellence which would enable services to attract and retain qualified staff, and allow for ophthalmic capacity, expertise, and technologies to be pooled to ensure an efficient and sustainable service".

184. It stated that, to date, there had been "no commitment from the Welsh Government to make significant investments needed to implement the

[117] RoP, 20 March 2025, para 50

recommendations of the National Clinical Strategy", and called for the Welsh Government to "commit the necessary resources to facilitate the shift to a sustainable regional delivery model".

185. RNIB Cymru argued that health boards were unlikely to commit to a fundamental reorganisation of services without appropriate incentives, resources and ministerial direction, and that the lack of any such incentives currently had hindered the shift to a regional model of delivery.

186. It called for the Welsh Government to "set clear expectations, including milestones and targets for implementation of the National Clinical Strategy". It said the Welsh Government must also "equip the NHS Executive with the resources and powers it needs to drive operational change before we will begin to see progress towards a regional delivery model".[118]

187. Similar points were made by the RCOphth. Rhianon Reynolds, Llywydd of the Royal College of Ophthalmology, consultant ophthalmologist and clinical lead for ophthalmology in NHS Wales Performance and Improvement, told us:

> *"at the moment, whilst there's a nod to collaborative working in different regions of Wales, the way health boards are measured is still on a health board basis. So, (…) for example, in south-east Wales, where we have three different health boards working together, whilst we're asking each of those health boards to provide performance details to question their own waiting lists and so on, they are always going to default to what they're doing within their health board rather than working towards a regional way of working.*
>
> *Because we have this sort of measure on a year-by-year basis, and we have to get to a certain number by a certain number, done in a certain number, it doesn't really let you build that sustainable regional way of working."*[119]

188. In their evidence, health boards told us that they were working towards new care pathways to manage patients in community settings, thereby reducing demand on secondary care. However, efforts to maximise regional working remained underdeveloped beyond cataract care.

[118] Written evidence, OP02
[119] RoP, 20 March 2025, para 52

189. Michael Stechman, clinical director for ophthalmology and consultant general surgeon at CAVUHB, recognised the importance of regional working in trying to "unify waiting lists, so that we can spread demand across health boards and work collaboratively, and allow capacity to be used across all health boards in south and north Wales, rather than just working in silos".[120]

190. He quoted the example of the Vanguard theatres[121], which he told us had treated "approximately 4,000 people with cataracts, around 40 per cent of those being CAVUHB patients, and 60 per cent being patients from neighbouring health boards".

191. He said the health board was looking to bolster its vitreoretinal emergency service to provide a sustainable 24/7 service across south-east and south Wales, rather than having to send patients over the border at weekends. He also referred to the need for regional working as a way to improve paediatric ophthalmology services within the health board.[122]

192. Dr Pyott also talked about the importance of decreasing cross-border surgeries and transfers. He told us that, without this, money from Wales was leaving Wales for other health authorities, and it was "much better to keep the money to develop your own services within the country". He said:

> *"(…) frequently, particularly when it comes to vitreoretinal surgery, the bulk of the treatment will be given by surgeons in training, once they've been trained up to a certain degree of competence that they can be allowed to be the first port of call to deliver that service.*
>
> *At the moment, I would say that Bristol is very happily having its training programme subsidised by the Welsh taxpayer, and it would be much better for the Welsh taxpayer to be preparing the next generation of VR surgeons for your country."*[123]

193. Andrew Carruthers, Chief Operating Officer, HDdUHB, referred to the recently established regional eye care board for the south-west Wales region, saying, as part of that, the health boards had committed to recruit two consultant posts with Swansea Bay UHB to work across the south west region. Longer term, he said

[120] RoP, 14 May 2025, para 174
[121] Temporary ophthalmic facility installed in University Hospital of Wales, Cardiff, including two operating theatres, consultation room and short-stay ward.
[122] RoP, 14 May 2025 para 231-233
[123] RoP, 220 March 2025, para 265

the vision was to "develop a fully integrated south-west Wales regional eye care service with joint governance, workforce, a single operational structure".[124]

194. In terms of the governance for such regional working arrangements, Andrew Carruthers told us:

> *"the first point (...) is the commitment of organisations to work together and want to do that and utilise resources in that way. It gets you a significant chunk of the way there; it's just about how you then legally cover that in terms of liability and various other issues in terms of those services. I think there's a way to do it, but (...) it's quite complex to work through the detail in that space, from experience."*[125]

Evidence from the Cabinet Secretary

195. "Regional collaboration across specialties" is one of the Welsh Government's four key priorities for ophthalmology.[126]

196. In his written evidence, the Cabinet Secretary stated:

> *"It is clear that for many services, a regional solution can be an effective approach that consolidates workforce, technology and estates more effectively to respond to demand and the national ophthalmology strategy supports regional working for many of its clinical conditions.*

197. He notes that this approach has been adopted in both south-east and west Wales and, whilst it will not replace NHS provided services, it will "act as an enabler" to the transformation of ophthalmology services across Wales. He goes on to state:

> *"Regional governance arrangements supported by regional reporting will be used to manage regional delivery in addition to individual health board accountability."*[127]

198. During our oral evidence session, we challenged the Cabinet Secretary on progress towards regional working. He told us there were good practice examples of regional working right across Wales, including in the south-east where "we saw

[124] RoP, 14 May 2025, para 235-240
[125] RoP, 14 May 2025, 243
[126] Written evidence, Welsh Government
[127] Written evidence, Welsh Government

about an 88 per cent reduction in the longest waits over the last few months (…), driven largely by regional working".[128]

199. He said that, where examples such as this could be better delivered at a regional level, "then the funding needs to go in at a regional level". Health boards would then agree how that funding would be allocated, based on the individual components they were able to offer. This, he said, represented a "national strategy for delivery at a regional level".[129]

200. We asked the Cabinet Secretary what more the Welsh Government could do to remove barriers to regional working by health boards, including providing assistance with governance arrangements. He told us:

> *"what we can do is what we have done, which is direct the establishment of a regional board in both the south-west and the south-east. Betsi is different—it's its own region. So, the board then has a collective responsibility for the entire local population of the combined region. We've seen that already starting to work in the south-west. The board's been in place for (…) coming up to a year, possibly, at this point. (…) And the new board now in the south-east is about to meet (…)."*[130]

201. We questioned the Cabinet Secretary about whether NHS Performance and Improvement (previously the NHS Executive) had the necessary tools to support the transformation of specialist eye care services. He told us that the "tools that are required by the NHS executive to support the NHS, are twofold—one is budget and the second is capacity and capability".[131] In relation to the latter, he said:

> *"(…) where I want to get to is that the NHS performance and improvement team is the first port of call for any health board thinking, 'I've got a challenge here that I want to improve this service, who do I go to?' It's the people at NHS performance and improvement. That's the culture I want to establish."*[132]

202. In relation to budget, he confirmed that the Welsh Government would be carrying out a "zero-based review" of the funding for NHS Performance and Improvement to make sure it is "perfectly aligned with national priorities". He also

[128] RoP, 5 June 2025, para 279
[129] RoP, 5 June 2025, para 280
[130] RoP, 5 June 2025, para 291
[131] RoP, 5 June 2025, para 298
[132] RoP, 5 June 2025, para 299

said he intended to appoint a managing director into the performance and improvement team to "streamline and focus all the incredible resource and expertise that we have" on the team's key priorities".[133]

Our view

203. The National Clinical Strategy clearly states that the future of eye care in Wales must be based on a regional model of care, with specific governance, finance and planning arrangements. Whilst we have seen some steps taken towards this by the Welsh Government and health boards, they have so far fallen short of their ultimate goal of transforming secondary eye care services in Wales.

204. We welcome the establishment of the two regional boards in the south east and south west. But progress with delivery of their regional strategies has been slow, with regional working remaining underdeveloped beyond cataract care.

205. Stronger direction is therefore needed in the regional delivery of ophthalmology services. The Welsh Government must go further in mandating regional working, including setting clearer expectations, milestones and targets for implementation, and requiring ophthalmology-related targets and plans to be delivered on a regional basis rather than within the traditional health board boundaries.

206. It must ensure that the new regional arrangements are underpinned by the necessary governance and infrastructure to make the regional delivery model sustainable in the medium to long-term, not a 'quick-fix' to deal with the immediate pressures of lengthy waiting lists.

207. Further, it must commit to providing the necessary financial investment to enable the successful delivery of a regional eye care model that is capable of meeting the predicted future demand. This would involve a multi-year, ring-fenced investment programme for secondary ophthalmology services that matches the scale and ambition of the £30m recurrent funding already provided to reform primary care optometry. This investment should cover the development of a sustainable regional eye care model, including upgrades to the estate, replacement of essential equipment, and expansion and retention of the specialist workforce. Without this, the transformation of eye care services will remain incomplete and the benefits of primary care reform will be undermined.

[133] RoP, 5 June 2025, para 300

Recommendation 10. The Welsh Government must be stronger in directing the regional delivery of ophthalmology services in Wales, as set out in the National Clinical Strategy. It must:

- develop and publish a set of expectations for implementation of the regional model provided for in the national strategy, with defined milestones and targets to track progress against delivery;
- require ophthalmology-related targets and plans to be delivered on a regional basis;
- ensure the necessary governance and infrastructure arrangements are put in place to underpin a sustainable regional delivery model of secondary eye care in Wales;
- commit to a multi-year, ring-fenced investment programme for secondary care that matches the scale and ambition of the recurrent funding already provided to reform primary care optometry. This investment should support the development of a sustainable regional eye care model, including estate upgrades, equipment replacement, and workforce expansion and retention, as set out in the National Clinical Strategy for Ophthalmology.

208. Specifically in relation to the two regional eye care boards, the Cabinet Secretary should set out the arrangements that are in place for him to have oversight of their progress, including any reporting arrangements.

Recommendation 11. In response to this report, the Cabinet Secretary should set out the arrangements that are in place for the Welsh Government to have oversight of the progress of the regional eye care boards in implementing the National Clinical Strategy, including details of any regular reporting requirements. He should also commit to publishing details of the progress of these regional boards.

7. Estates and equipment

> *"We've got another person who was having laser treatment at Abergele eye hospital. Their laser broke and then there was a long gap between him being picked up then by the Maelor hospital. In that time, he had leaking blood vessels in his eyes and that ended up clotting, and they had to stop the laser treatment because it wasn't going to work any longer."*[134]
>
> *Lowri Bartrum, Vision Support*

Evidence from stakeholders

209. Stakeholders told us that, although capacity of ophthalmology estates to meet demand is a UK-wide problem, "Wales has particularly severe challenges with both the capacity and condition of its estates"[135].

210. In making this point, the Royal College of Ophthalmologists quoted the National Clinical Strategy for Ophthalmology, which found:

> *"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 impairments to navigate, creating accessibility issues for the people most in need of our help."*[136]

211. In terms of clinical space, Rhianon Reynolds, Llywydd of the Royal College of Ophthalmology, consultant ophthalmologist and clinical lead for ophthalmology in NHS Wales Performance and Improvement, was clear that:

> *"we don't have enough rooms, we don't have enough theatres. (…) we don't have enough space in secondary care for our*

[134] RoP, 20 March 2025, para 551
[135] Written evidence, OP01
[136] Written evidence OP01

> *doctors to work, let alone, then, bringing optometry into secondary care to train them to be able to take that back out into community."*[137]

212. She told us that ophthalmology "needs a bespoke space" and couldn't "slot in" to other out-patient spaces. She said that, whilst there were estates within Wales that could be repurposed for ophthalmology, including on a regional basis, investment would be needed to change those estates into ophthalmology-suitable spaces.[138]

213. William Oliver, Assistant Director, Strategic Programme for Planned Care, NHS Wales Executive, told us that, following visits to every hospital in Wales, the GIRFT [Getting It Right First Time] team had suggested ways to maximise the various estates. He said the team had also been outside Wales and had seen the "Exeter model" which was producing high-efficiency, high-quality services. He said it was "incumbent on us to try and look at those models, on a regional basis, if not on an each health board footprint, and start to follow those through."[139].

214. In their written evidence, health boards highlighted the significant challenges they face with the condition of their estates and their suitability to provide modern eye care services to patients. They referred to problems with aging facilities, saying that hospital estates are outdated, cramped, and insufficient to meet current and future demands. They also reported limitations in their ability to expand their capacity and to optimise their resources.

215. During an oral evidence session, we asked them whether there were any immediate steps that could be taken to make eye care services more accessible to prevent accidents and ensure safe care. Each of the health boards we heard from had plans in place to try to improve their own respective provision, including consideration of regional working, but all were clear about the negative impact their respective infrastructures had on their ability to deliver the services they wanted.[140] On this point, Catherine Wood, Director of Operations for Planned Care, CAVUHB told us:

> *"it would be remiss of me not to reference the fact that our estate, as it currently stands, is not fit for purpose for delivery of modern eye care services.*

[137] RoP, 20 March 2025, para 37
[138] RoP, 20 March 2025, para 94
[139] RoP, 20 March 2025, para 95
[140] RoP, 14 May 2025, para 257-265

> *And I think it does require significant investment in terms of our theatres and out-patient facilities in order to right-size that in terms of the actual footprint and the accessibility from a patient experience perspective that we've got, and that's a point I don't think I can emphasise strongly enough to this committee, in terms of the impact that our infrastructure has on our ability to deliver our services in the way we would like to."*[141]

216. Health boards also highlighted their capital investment needs, saying there was a significant need for investment in upgrading facilities and equipment to support service growth, particularly in pre-operative assessment and cataract care.

217. Rhianon Reynolds told us that most health boards did not have a process in place to replace such equipment coming to the end of its useful life. She said that such an approach would require capital investment, and that Ophthalmology had to "battle with other specialties within the health board" for this. She told us that there was "a lack of understanding" that these pieces of equipment were essential in order to be able to perform services[142], and she gave an example of the consequences of a broken microscope in her own health board:

> *"(...) in Aneurin Bevan, we have two eye theatres, so 50 per cent of our capacity would be limited until we can get that microscope up and running. While it's not essential for all ophthalmology surgery, it means that cataracts can't be done, for example, any intraocular surgery can't be done, glaucoma surgery, corneal surgery and so on. So, we're at 50 per cent capacity until that is fixed.*
>
> *It extends waiting lists, it extends waiting times for patients."*[143]

Evidence from the Cabinet Secretary

218. We challenged the Cabinet Secretary on the poor condition of health board eye-care estates. He told us that, since 2017-18, just under £12m of capital investments had been provided to health boards, NHS trusts and training

[141] RoP, 14 May 2025, para 265
[142] RoP, 20 March 2025, para 99
[143] RoP, 20 March 2025, para 114, 116

providers[144]. Notwithstanding this investment, he said that the focus now was on delivery of services differently:

> *"One of the key ways in which we can improve access and improve speed of access as well is by delivering services increasingly at a regional level, rather than solely at a health board level. (…) Increasingly, that's how I expect more and more services to be delivered.*
>
> *So, for example (…) if you look at the south-west, Swansea bay health board may have a particular configuration of assets and Hywel Dda will have a different configuration. If we're looking at delivering that regionally across those two health boards (…) then we need to make sure that the mix of assets across the two health boards, across the sites in both health boards, deliver what we need.*[145]

219. He said that the clinical implementation network was working "to understand what the current picture is, as part of that regional change, and then, when we have that, we'll be able to implement and make the investments that we need to".[146]

220. Further, he told us:

> *"I'm not prepared for us to continue to invest capital at a health board level for services that are better delivered at a regional level. (…) We have to move the investment strategy to drive the outcomes that we want to see. And if, as in this case, (…) the way of delivering the service in a way that is better for patients, better for value for money, more sustainable, is all the things that we all want to see, where the answer to that is regional, that is where the capital will be invested."*[147]

221. We questioned the Cabinet Secretary on the investment that was being provided to update and replace equipment nearing the end of its life. He told us there were a "range of investments", in terms of capital investment, and for particular items of equipment or facilities. He cited examples of "two of the most exciting investments", one in Cwm Taf Morgannwg UHB involving the

[144] Written evidence, Welsh Government
[145] RoP, 5 June 2025, para 213
[146] RoP, 5 June 2025, para 213
[147] RoP, 5 June 2025, para 220

procurement of several 'SurgiCubes' focused on eye surgery, and the other in Cardiff University, where a simulation suite is being used to train ophthalmologists.[148] He said these were good examples of productive capital investment in this specialty.

222. More broadly, the Cabinet Secretary told us that the maintenance backlog facing the NHS Wales estate was likely to be in the region of £1 billion currently, and that financial constraints meant this problem was "many, many, many years" away from being able to be addressed. However, he said it was possible to use the capital budget in a way that could make a difference, citing his previous examples in Cwm Taf Morgannwg UHB and Cardiff University.[149]

Our view

223. We were shocked to hear of the appalling condition of the secondary eye care estate in Wales, which is simply not fit for purpose for patients or clinicians. Whilst work has been undertaken by the GIRFT team and the clinical implementation network to assess the condition of the estate and suggest improvements, this is happening late in the day when the overall situation is already bleak. Moreover, we are concerned that there is a worrying acceptance of the poor overall condition of the estate, and a lack of urgency in improving it.

224. The Cabinet Secretary told us that the Welsh Government had invested just under £12 million in hospital and clinical infrastructure for ophthalmology since 2017. In the context of NHS infrastructure investment, this is a relatively modest amount, especially when spread across clinical and hospital infrastructure for all Welsh health boards. Although we appreciate that the overall aim is to move away from health board-based services to a regional model, slow progress has been made to date and the model is currently far from being implemented fully. In the meantime, the condition of the ophthalmology estate and equipment is unacceptable.

225. As we have stated earlier in this report, the Welsh Government needs to commit to providing the necessary financial investment to implement the regional delivery model set out in the National Clinical Strategy. In the meantime, however, there needs to be a renewed focus from health boards and partners on maximising the current estate and implementing improvements that have been

[148] RoP, 5 June 205, para 215-216
[149] RoP, 5 June 2025, paras 230-231

proven to work elsewhere. There should also be proper consideration and planning for upgrading and replacing equipment nearing the end of its useful life.

Recommendation 12. Welsh Government and NHS Performance and Improvement should require health boards to demonstrate that they are:

- maximising the current ophthalmology estate, including implementing improvements that have been proven to work elsewhere and submitting business cases for capital investment where appropriate,
- developing and maintaining a rolling equipment replacement schedule, informed by clinical need and service demand, to ensure timely upgrades and avoid service disruption;
- working with NHS Wales Shared Services Partnership (NWSSP) to explore opportunities for centralised procurement, shared asset tracking, and coordinated capital planning.

Health boards should be required to write to our successor committee in twelve months' time to report on progress in these areas, including:

- the condition and suitability of their ophthalmology estate;
- planned and completed equipment upgrades;
- any outstanding risk to service delivery due to estate or equipment limitations.

8. Workforce

> *"**Medical workforce***
>
> *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 [hospital eye services] 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."*
>
> *The National Clinical Strategy for Ophthalmology*

226. The Welsh Government and NHS Wales Performance and Improvement set the overall policy, funding, and strategic direction for ophthalmology, but workforce planning involves multiple organisations due to the complexity of eye care services.

227. Health Education and Improvement Wales (HEIW) leads on training and developing the skills of eye care professionals. NHS Wales Shared Services Partnership (NWSSP) supports workforce co-ordination and recruitment across health boards. The Eye Care Wales Committee oversees the implementation of advanced eye care pathways to ensure consistent service delivery.

Evidence from stakeholders

228. Stakeholders highlighted the workforce as one of the main challenges to improving ophthalmology services for patients, expressing concerns about not having sufficient workforce in place to meet rising demand.

229. Rhianon Reynolds, Llywydd of the RCOpth, consultant ophthalmologist and clinical lead for ophthalmology in the NHS Executive, told us that the "main barrier" to improving the delivery of ophthalmology services was workforce, which she described as "a significant limiter in Wales". She said:

> *"We have problems in all aspects of our secondary care ophthalmology services. That includes medical, nursing; our hospital optometry departments are non-existent in lots of health boards."*[150]

230. She said that Wales was "woefully under-resourced" right across the board in terms of consultant ophthalmologists, describing some areas of Wales as "a desert for ophthalmologists."[151] Further to this, written evidence from the RCOphth cited the much lower number of consultant ophthalmologists per population head in Wales than most of the rest of the UK, which it said was "far below our minimum recommended ratio of 3 to 100,000 to deliver effective hospital eye services".[152] Similar points were made by the RNIB, who also stated that, "in Europe, only North Macedonia has fewer consultant ophthalmologists per capita than Wales".[153]

231. The RCOphth stated that many sites, particularly in West Wales, faced significant recruitment and retention issues, and this was leading to an increased reliance on locums to fill gaps.[154]

232. It recommended a "phased approach to filling ophthalmology specialty training places", with an additional 36 places by 2031. It also recommended:

> *"that the Welsh Government adopts a granular approach to workforce planning, taking into account prevalence of data for all eye conditions and the optimum workforce team needed to manage care."*[155]

233. It confirmed it had begun to undertake this work for each sub-specialty through expert working groups.[156]

[150] RoP, 20 March 2025, para 7
[151] RoP, 20 March 2025, para 36
[152] Written evidence, OP01
[153] Written evidence, OP02
[154] Written evidence, OP01
[155] Written evidence, OP01
[156] Written evidence, OP01

234. In their written evidence, health boards identified three main challenges with the workforce, namely recruitment and retention; training limitations; and role expansion. They described persistent issues with recruiting and retaining qualified ophthalmic specialists, hospital optometrists, and multidisciplinary team staff. They said there was insufficient capacity to develop staff to their full potential due to space and resource constraints with training. They also told us of the need to upskill optometrists and other practitioners to take on extended roles, particularly in referral refinement and pre-assessment care, to alleviate pressure on secondary services.

235. HEIW recognised the need to increase the number of training posts in Wales, but told us that training capacity (which includes availability of trainers and placements) was a factor that was currently limiting the pace at which the undergraduate programme could be expanded.[157]

236. It stated that any expansion in training numbers would be achieved through HEIW's annual Education and Training Plan, and was dependent on funding approval. It said that, once training capacity issues were addressed, an increase in training posts "would be facilitated in a phased manner ensuring the delivery of sustainable, high-quality training aligned to GMC standards is maintained".[158]

237. HEIW also told us that, as part of its aim to increase the focus on ophthalmology, it had, on 1 April 2025, established a Specialty Training School dedicated to the specialty and had appointed a Head of School. Part of the role of the Head of School was to improve recruitment and retention in the training programme and into consultant posts, to promote ophthalmology as a career at an early state of medical training, and to explore opportunities to expand the ophthalmology programme.[159]

238. Linked to this, HEIW told us that they track and monitor their trainees once they have qualified in order to find out where those trainees go to work. They said this clearly showed that:

> *"immediately after CCT [certificate of completion of training] or within that first 12 months, we do not retain our trainees in Wales".*[160]

[157] Written evidence, OP10
[158] Written evidence, OP10
[159] Written evidence, OP10
[160] RoP, 21 May 2025, para 43-44

239. HEIW said it continued that tracking for a number of years post-CCT and was "starting to see that some of those numbers are trickling back". HEIW recognised the need to consider how Wales can retain its post-CCT trainees, without them needing to leave Wales to undertake fellowships. They said that, whilst the new curriculum offered some scope to achieve this, it would take time for that to become common practice.[161]

240. Rhianon Reynolds highlighted issues with the arrangements for ophthalmology recruitment into training, saying that this was a national process, carried out through the royal college for the whole of the UK. She believed more local control would make a big difference to recruitment and retention of staff:

> *"When I was recruited into ophthalmology, it was local recruitment, so I applied to the places I wanted to work, and I've been fortunate enough to do everything within Wales. I'm from Wales, I wanted to stay in Wales. We can no longer give our junior doctors that guarantee, and I think it's something that we would like to do."*[162]

241. In relation to current trainees, HEIW told us that they had, very recently, begun to benefit from Welsh Government investment in Cardiff University simulation facilities. HEIW said that it provided funding to Cardiff University to ensure that its trainees could attend those simulation facilities on a weekly basis, providing them with the access to high-quality technical facilities and equipment, and also giving them an opportunity to meet collegiately as a team of individuals for their education and training.[163]

242. HEIW also told us that, once trainees had completed their certificate of training, its own remit ceased and health boards became responsible for taking on those individuals as consultants. To assist with this, HEIW has developed a 'CCT [certificate of completion of training] dashboard' to share information with health boards about the numbers of individuals due to complete their training, so that health boards can build this into their workforce planning.[164]

243. More broadly, stakeholders, including Rhianon Reynolds, highlighted the lack of a workforce plan for ophthalmology in Wales, saying that such a plan was really needed. CAVUHB said a strategic workforce plan for Wales would ensure "that the

[161] RoP, 21 May 2025, para 43-44
[162] RoP, 20 March 2025, para 135
[163] RoP, 21 May 2025, para 28
[164] RoP, 21 May 2025, para 29

workforce that we grow in Wales stays in Wales and is fit to meet both our community demand and also the demand that will still necessarily remain within secondary care in terms of the waiting times".[165]

244. The College of Optometrists told us "there is an urgent need to understand eye care workforce requirements now and in future, in order to meet patient need and improve outcomes". It said that its 'UK Eye Care Data Hub' modelled the expected changes in the workforce of all eye care professions at a national and health board level in Wales. The College said that this work indicated the expected changes in workforce if no changes were made to education and training provision or to working practices, which included a predicted decrease in ophthalmic nurses by 30% by 2035. It said that this model should help commissioners to "make best use of the existing workforce and identify where to invest to ensure ophthalmic professions are maintained".[166]

245. We asked HEIW whether it had conducted a review of the ophthalmology workforce, following the Audit Wales report in 2023[167] which highlighted gaps in the ophthalmology workforce. They told us that they get information about the medical workforce "from a variety of sources", usually external, including colleges, specialities and associated professions and health boards.[168]

Multidisciplinary team

246. More broadly, we heard about the importance of the multidisciplinary team in ophthalmology. William Oliver, Assistant Director, Strategic Programme for Planned Care, NHS Wales Executive, told us that the service was "reliant on our nursing teams and our theatre teams" just as much as ophthalmologists. He said that, whilst work was underway to get consistent job descriptions and standardised team models based on a royal college blueprint, this was "definitely an area that's fragile at best and is a risk for us still".[169]

247. Similarly, Dr Andrew Pyott told us:

[165] RoP, 14 May 2025, para 172
[166] Written evidence, OP04
[167] *Review of Workforce Planning Arrangements – Health Education and Improvement Wales*, Audit Wales, October 2023
[168] RoP, 21 May 2025, para 10
[169] RoP, 20 March 2025, para 128

> *"(...) if there are three things that would best equip units to be efficient, it's have a dedicated nursing team, have a dedicated nursing team, and have a dedicated nursing team."*[170]

248. He supported the use of dedicated ophthalmology wards and, particularly, theatre teams, saying that "throughout my travels around the world, I'd say that the most efficient eye departments are those that have a semi-autonomous governance and that are not impacted too much by other departments trying to influence the way they work".[171]

249. He also advocated having nurses who are able to move across different specialty areas, both as a means of career development and also to create flexibility and capacity to relieve pressure within different specialties.[172]

250. We questioned HEIW about Dr Pyott's evidence about the importance of dedicated ophthalmology nursing teams, and how they could support that model. They told us that, whilst they commissioned training in nursing ophthalmology, there wasn't always an awareness amongst nurses that such specialist training was available to them. In addition, they told us there could be a shortage of trainers in nursing which could lead to difficulties in finding enough accreditors.[173]

Optometry workforce

251. In relation to community optometry, HEIW noted there were "few if any outstanding vacancies" and currently no significant waiting lists for patients requiring eye care appointments.

252. HEIW told us that, from March 2025, it had started asking every optometry practice to put forward its workforce data on a monthly basis. HEIW told us it was waiting for the first outputs from that workforce data, which would "give us our first kind of full mapping" of the current workforce, helping to "inform its understanding of the demographics, structure and shape of the optometry workforce, particularly in rural areas, such as North West Wales where there have been some practice closures". It went on to state:

> *"Linking workforce data with the Health Boards' eye care needs analysis will be a key component of our strategic workforce*

[170] RoP, 226-227
[171] RoP, 20 March 2025, para 244
[172] RoP, 20 March 2025, para 227
[173] RoP, 21 May 2025, para 79

> *plan, enabling a more targeted and informed approach to workforce development and service planning."*[174]

253. The College of Optometrists also referred to the requirement for all optometry practices to submit monthly workforce data, including skillsets and higher qualifications. It told us that this data would help to identify any workforce shortages which could be used to support targeted interventions for a particular qualification or in a specific geographic area.[175]

254. The College of Optometrists and Optometry Wales also referenced the establishment (with Welsh Government support) of three Teach and Treat Eye Care Centres in North, West and South Wales which, it said, helped "to reduce hospital waiting times for patients requiring eye care, while providing in a clinical environment the skills required for optometrists in Wales to deliver a greater range of eye care services in primary care settings."[176]. Owain Mealing, Chair of Optometry Wales, told us that these clinics have been "essential for delivering the higher qualifications for optometry".[177]

255. In relation to undergraduate education and training, HEIW informed us that recent changes to the optometry undergraduate programme at Cardiff University were expected to further integrate enhanced skills qualifications into the primary degree. It noted that this approach would require additional clinical placements for undergraduates, and that this would be challenging for the University.[178]

256. Looking ahead, HEIW stated that the current profile of optometry students at Cardiff University showed that only 111 out of 442 students (25%) were from Wales, and that fewer than 20 Welsh students in total were studying optometry elsewhere in the UK. It cited evidence that approximately 15% of the workforce was looking to retire within the next 10 years, raising concerns about the sustainability of the locally-trained optometry workforce and the long-term ability to meet service demand across Wales.

257. HEIW told us that, in response to this, it was:

> *"developing strategies to promote optometry as a career pathway and increase engagement with learners. An options appraisal is planned to identify and evaluate potential*

[174] Written evidence, OP10 and RoP, 21 May 2025, para 12
[175] Written evidence, OP04
[176] Written evidence, OP04
[177] RoP, 20 March 2025, para 417
[178] Written evidence, OP10

> *solutions aimed at creating a sustainable optometry workforce for the future."*[179]

258. In relation to optometrists working in hospital ophthalmology units, HEIW told us there "there have traditionally been barriers between ophthalmology, medical and optometrists. Those are coming down (…) and that's why we feel that there could be more optometrists working in hospitals". However, it said the main barrier continued to be financial, as a result of salary discrepancies:

> *"At the moment, if you're working in a high-street optometry practice, you can command a much higher salary than you would do if you worked for the NHS."*

259. HEIW told us it had "put together a better career structure and banding in optometry for those working in the NHS directly, in ophthalmology hospitals" in order to make a more attractive proposition, but that the salary still didn't reach the same levels as high street optometry.[180]

Evidence from the Cabinet Secretary

260. "Workforce optimisation" is one of the Welsh Government's four key priorities for ophthalmology.[181] In his written evidence, the Cabinet Secretary refers to a Strategic Programme for Primary Care, which he says is developing "a comprehensive workforce strategy", to meet future demand. Local health boards then deliver services based on these plans.

261. In a written statement on 20 December 2024, the Welsh Government published a report of its recent ministerial summit, which included an action for HEIW to conduct a workforce review to identify gaps and needs across all levels of ophthalmology staff, including non-clinical roles.

262. We challenged the Cabinet Secretary about the low ratio of ophthalmology consultants in Wales compared to the rest of the UK. He said that the trend of recruitment in the specialty over the last five years had been "positive" with "about a 16 per cent increase, but he acknowledged that this needed to continue and to "increase in pace".[182]

[179] Written evidence, OP10
[180] RoP, 21 May 2025, para 84 and 137
[181] Written evidence, Welsh Government
[182] RoP, 5 June 2025, para 254

263. Similarly to Rhianon Reynolds, he referred to the challenges posed by national-level training arrangements for ophthalmologists, saying that this meant that "sometimes people end up being trained in areas that are not areas of their first choice". He said that, where training placements were not provided in an individual's area of first choice, this could lead to them either leaving that area at the end of their training programme or, in some cases, during their training programme. There was a need, he said, to "rectify" this challenge".[183]

264. He referenced the recent HEIW appointment of a head of school of ophthalmology, saying that person had been tasked with, amongst other things, "developing a specific recruitment programme, which would operate at a Wales level rather than at a UK level". He thought would help to improve retention by making it more likely that people who wished to practice in Wales would apply through that programme.[184]

265. He confirmed that he had "not yet" set a target for NHS Wales in terms of the number of consultant ophthalmologists per head of population, but was "open to doing that" based on the information and assessments from the new ophthalmology head of school.[185]

266. We questioned the Cabinet Secretary about the current workforce planning projections of a 6.4 per cent increase in demand for ophthalmic services by 2030, which would be significant. We asked whether there might be some specialties which were not able to reach that 6.4 per cent.

267. David O'Sullivan, the Chief Optometric Adviser for Wales, said that the integration of the primary and secondary care eye care pathway and the move to regional working "will make a huge difference" to the workforce by breaking down the current divide between ophthalmology and optometry, and creating integrated training opportunities between the two areas.[186]

268. In relation to Dr Pyott's evidence about the importance of dedicated ophthalmology nursing team, the Cabinet Secretary said that, whilst the "main responsibility for delivering on that is at a health board level, the piece of work that needs to inform that is the clinical strategy work". He said that having HEIW

[183] RoP, 5 June 2025, para 255
[184] RoP, 5 June 2025, para 256
[185] RoP, 5 June 2025, para 262
[186] RoP, 5 June 2025, para 272-273

and that piece of work aligned closely "will be critical to making sure that we are able to get the range of nursing and non-medical workforce in the right place".[187]

Our view

269. Sufficiency of the workforce is one of the main challenges in the delivery of improved ophthalmology services. Despite efforts by health boards to recruit into consultant ophthalmic posts, issues with recruitment and retention of staff in many areas, particularly west Wales, have led to persistent shortages in medical, nursing and allied health professionals, and well as high turnover and burnout rates amongst those staff and an increased reliance on locums.

270. A sustainable future workforce requires planning and investment, particularly in training the next generation. There is a clear need to increase the number of ophthalmology specialty training places, and the Royal College has called for an additional 36 places by 2031, implemented via a phased approach. We note that HEIW has accepted the need for an increase in places, and we recognise that efforts in this area have, in part, been limited by having insufficient staff currently to provide the necessary training and supervision. HEIW told us that, once training capacity issues were addressed, an increase in posts would be facilitated a phased manner. We urge HEIW to progress the work to address these training capacity issues with pace, and we call on the Welsh Government to commit to providing funding for additional training places, when identified as part of HEIW's annual education and training plan.

271. Linked to this, we welcome the recent establishment by HEIW of a new specialty school for ophthalmology, and the appointment of a new Head of School. We believe this will raise the profile and provide an increase in focus on ophthalmology. We note the broad remit for the new Head of School to improve recruitment and retention into ophthalmology training and consultant posts; to promote the specialty as a career, and to look to expand the ophthalmology programme. We also note that consideration is being given to developing a specific trainee recruitment programme for Wales to give applicants greater choice. We ask that HEIW writes to us in due course with an update on the work of the new school.

Recommendation 13. In its response to this report, HEIW should provide us with an update on the work of its specialty school for ophthalmology and the Head of School. This update should include:

[187] RoP, 5 June 2025, para 275

- progress with initiatives to improve recruitment and retention of ophthalmology trainees and consultants;
- actions taken to promote ophthalmology as a career;
- steps to expand the ophthalmology training programme, including any curriculum developments or new training pathways;
- details of progress with developing a specific trainee recruitment programme for Wales, including timelines and expected outcomes, and
- key performance indicators to track progress, such as number of new training posts created, percentage of trainees retained in Wales post-CCT, uptake of enhanced training opportunities and regional distribution of trainees and posts.

Recommendation 14. In its response to this report, HEIW should provide us with an update on the specific actions being undertaken to address training capacity limitations in ophthalmology, including:

- milestones for expanding training infrastructure and supervision capacity;
- plans for a phased increase in specialty training places, aligned with projected demand and workforce modelling;
- any barriers to expansion and proposed solutions.

Recommendation 15. The Cabinet Secretary should commit to providing funding for additional ophthalmology specialty training places identified by HEIW in its annual education and training plan, ensuring sustainability and alignment with the scale of investment already made in primary care optometry.

272. In addition to increasing the number of new training places, there must be a strong focus on retaining trainees, post-qualification, and attracting back those who have previously left. We recognise the work being done in this area by HEIW, including the introduction of a new curriculum and other initiatives aimed at improving retention. However, these measures will take some time to show their impact, and it is essential that progress is tracked through clear performance indicators. This includes monitoring the percentage of trainees retained in Wales after completing their training, uptake of enhanced training opportunities, and the regional distribution of posts. These metrics will be vital in assessing the

effectiveness of HEIW's specialty school for ophthalmology and its broader workforce strategy.

273. More broadly, and given the well-known risks with the fragility of the current workforce, we believe there is a pressing need for a strategic, cross-professional workforce plan for ophthalmology to identify and address current gaps and plan for future provision. Subspecialty modelling, as part of this, would help ensure the right mix of skills and roles are developed across Wales.

274. We note that, during the 2024 Ministerial summit, the Cabinet Secretary charged HEIW with conducting a workforce review to identify gaps and needs across all levels of ophthalmology staff, including non-clinical roles. This work will be an important step in the production of a workforce plan, and we ask HEIW to update us on progress with this review.

Recommendation 16. In its response to this report, HEIW should provide us with an update on its ophthalmology workforce review, including timelines for completion and early findings.

Recommendation 17. HEIW should commit to producing a strategic, cross-professional workforce plan for ophthalmology, covering medical, nursing, optometry and allied health professionals. This plan should:

- be informed by regional demand modelling and workforce data;
- include actions to improve retention post-CCT;
- identify future workforce needs across subspecialties;
- be published before the end of February 2026.

275. We were concerned by the evidence that Wales has a much lower number of consultant ophthalmologists per head of population than the rest of the UK. Whilst the Cabinet Secretary has indicated he is open to setting a target for NHS Wales in this area, we recognise that a blunt numerical target may not be the most effective tool given the current recruitment challenges faced by health boards. Instead, we believe that a more strategic approach is needed—one that combines a longer-term expansion of training places, a renewed focus on retaining post-qualification trainees, and the use of regional working models to pool resources and improve recruitment across health board boundaries. This approach would help to build a more sustainable consultant workforce and ensure that services are better aligned with projected demand.

276. The wider multi-disciplinary team is a critical part of the delivery of hospital eye care services, and we believe that more can and should be done in this area, particularly in relation to the fragile nature of the ophthalmology nursing workforce.

277. We draw the attention of HEIW and health boards to Dr Pyott's evidence in this area, specifically in relation to the strategic value of dedicated ophthalmology nursing teams. We encourage HEIW and health boards to do more to promote the opportunities for nurses in the specialty of ophthalmology and to consider structured development pathways and retention strategies for ophthalmology nurses.

278. In relation to hospital optometry, we note the evidence that the wider WGOS reforms, and the move towards regional working, are beginning to break down the barriers which have traditionally existed between optometry and ophthalmology, and that more integrated training opportunities will be created as a result. We also note the work being undertaken by HEIW to improve the career structure and banding for hospital optometrists in order to make the role more attractive. We recognise that this work will take time to show results, and this might be a matter that a future Health and Social Care Committee may wish to follow-up.

Annex 1: Terminology

Glossary of Common Eye Conditions

Cataract: A clouding of the eye's natural lens, leading to blurry vision. Treated with cataract surgery, where the cloudy lens is replaced with an artificial intraocular lens (IOL).

Glaucoma: A group of eye conditions that damage the optic nerve, often due to high intraocular pressure. Treatments include medications, laser therapy, and surgery to lower eye pressure.

Macular Degeneration: A disease that affects the central part of the retina (macula), leading to vision loss. There are two types: dry and wet. Treatments include medications, laser therapy, and lifestyle changes.

Diabetic Retinopathy: A complication of diabetes that affects the blood vessels in the retina. Treatments include laser surgery, injections, and controlling blood sugar levels.

Retinal Detachment: A serious condition where the retina pulls away from its normal position. It requires prompt surgical treatment to reattach the retina and restore vision.

Corneal conditions: These are various disorders that affect the cornea, which is the clear, dome-shaped surface at the front of the eye. Common corneal conditions include, keratitis (an inflammation of the cornea, often caused by infections related to contact lenses), and dry eye syndrome (a condition where the eyes don't produce enough tears, leading to discomfort and vision problems).

Optometry

Optometry is the branch of healthcare focused on examining, diagnosing, and treating visual problems and eye conditions. Optometrists perform eye exams, prescribe glasses or contact lenses, and may also detect early signs of eye diseases like glaucoma or cataracts, but they do not perform surgery.

Annex 2: Welsh General Ophthalmic Services (WGOS)

There five levels of service under the Welsh General Ophthalmic Services (WGOS). These are:

- Eye Examination: routine eye examinations to assess vision and eye health (WGOS 1).
- Examinations for Urgent Eye Problems: assessments for urgent eye conditions that require immediate attention (WGOS 2).
- Low Vision Assessment: comprehensive assessments for individuals with significant vision impairment to provide appropriate aids and support (WGOS 3).
- Referral Refinement/Monitoring: follow-up and monitoring of patients with specific eye conditions to refine referrals and manage ongoing care (WGOS 4).
- Independent Prescribing: optometrists authorised to prescribe medications independently for various eye conditions (WGOS 5).