



Deep Dive: Ophthalmology

Quality, Safety and Experience Committee

June 2026



The purpose of this report is to provide the Quality, Safety and Experience Committee with assurance on the current position of ophthalmology services, including the impact of capacity, workforce and pathway pressures on quality, safety, effectiveness and timely access to care.

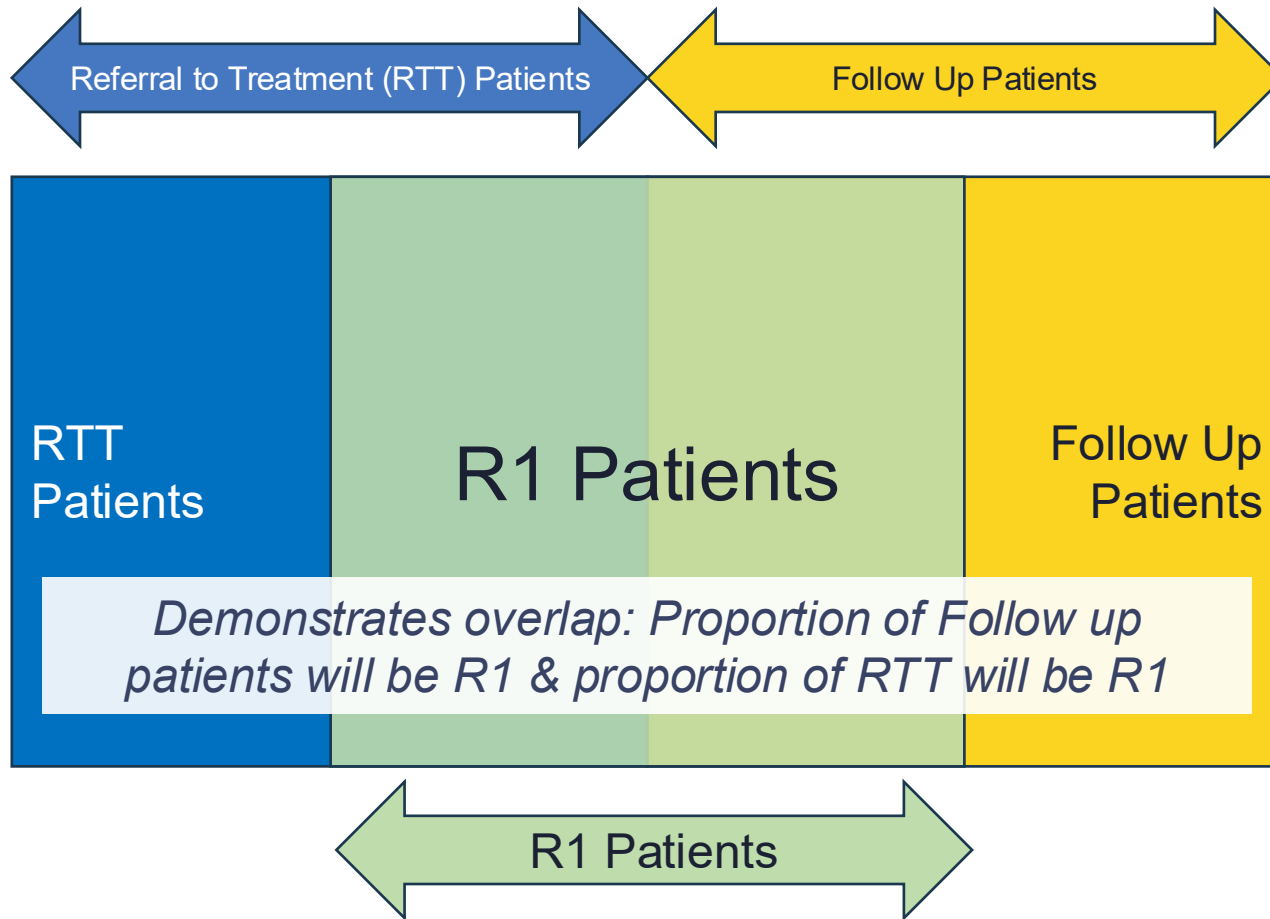
This report highlights the principal risks affecting ophthalmology services, including sustained demand, treatment and follow-up backlogs, workforce constraints, diagnostic capacity and the actions in place to mitigate these pressures.

Background: Ophthalmology



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- **Medical retina** – e.g. Age-Related Macular Degeneration (AMD), diabetic retinopathy, retinal vascular disease
- **Vitreoretinal surgery** – retinal detachment, macular surgery
- **Glaucoma** – medical and surgical management of raised intraocular pressure
- **Cornea & external disease** – keratoconus, infections, corneal transplants
- **Cataract & refractive surgery** – cataracts, lens implants, laser vision correction
- **Oculoplastic (adnexal)** – eyelids, lacrimal system, orbital conditions
- **Paediatric ophthalmology & strabismus** – childhood eye disease, squints
- **Neuro-ophthalmology** – visual problems related to the nervous system
- **Uveitis** – inflammatory eye diseases
- **Ocular oncology** – eye tumours



* R1 – a patient whose clinical condition means they require urgent assessment and/or treatment, and cannot safely wait the standard (routine) waiting time

Background: Ophthalmology Risks



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Risk Ref	Title	Tolerable score	Current rating (trend)	Target rating (LxI)	Overdue actions
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	6	4x4=16 (↔)	2x4=8	0 of 26 (↔)
2142	Risk of being unable to provide consistent IVT service due to lack of specialist staff to allow capacity to meet demand		4x4=16 (↔)	1x4=4	1 of 3 (t)
2066	Inability to conduct basic slit-lamp examination for some patients due to lack of a portable hand-held slit-lamp	6	4x3=12 (↔)	1x3=3	1 of 1 (↔)
2071	Risk of inability to review and diagnose corneal patients adequately due to age of topographer		3x4=12 (↔)	2x4=8	2 of 3 (↔)
1960	Risk of potential misdiagnosis or inability to treat due to ageing Ophthalmology equipment		3x3=9 (↔)	2x3=6	0 of 18 (↔)
2232	Risk of harm to patients with urgent eye conditions due to the lack of a functioning laser machine		2x4=8 (↔)	1x4=4	1 of 2 (↔)
2157	Risk of delay to patient diagnosis due to unavailable OCT equipment in Tyndal Eye		2x3=6 (↔)	1x3=3	2 of 4 (↔)

1664 (Corporate Risk) – shortage of Consultant Ophthalmologists

- Ongoing workforce constraints present a risk to the safe, timely and effective delivery of ophthalmology services. Recent recruitment of 2 SAS doctors, 1 regional vitreoretinal (VR) consultant, and 2 trainees with supported job plans strengthens the workforce enabler and supports service resilience. The risk remains under review to ensure capacity, clinical sustainability and continuity of care.

2142 - Provision of consistent IVT service

- Capacity pressures within ophthalmology present a risk to the safe, timely and effective delivery of treatment, particularly in relation to intravitreal therapy (IVT) pathways. Mitigating actions include outsourcing to maintain patient safety, upskilling staff to deliver IVT, and embedding IVT activity within additional recruitment plans. Recent analysis of R1 compliance shows 82% of patients are seen within target against a 95% target, highlighting an ongoing risk to timeliness, effectiveness, and the information enabler through continued performance monitoring.

Equipment*

- Equipment availability and replacement remain a risk to the efficient, safe and effective delivery of care and continue to be reviewed in line with capital allocation. Current support arrangements from temporary senior nurse managers help maintain operational oversight during substantive senior nurse absence, aligning to the leadership and workforce enablers while longer-term arrangements are addressed.



Background: Complaints



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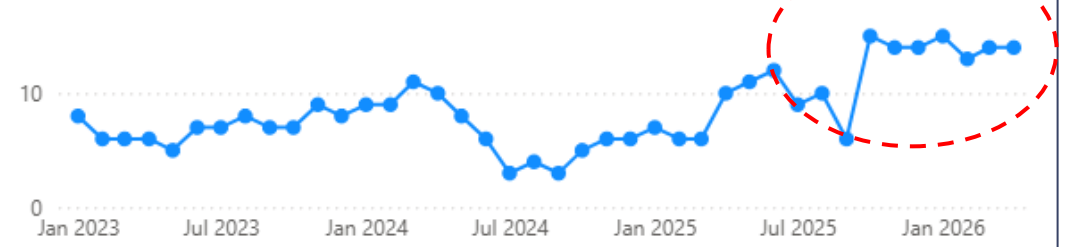
By month received



Number open complaints



Number of overdue complaints



- Complaints have reduced from 32 in August 2025 to 2 in April 2026 (to note – waiting list enquiries were managed as complaints but there has been a Health Board wide change to manage these as enquiries resolving the enquiry in a timely manner)
- Open complaints reduced from 35 in September 2025 to 17 in April 2026
- Overdue complaints remained static since October 2025 due to clinical lead capacity to provide final review (**Note:** Clinical lead session – 1 per week)
 - Plan to increase clinical review sessions pending additional medical workforce onboarding
- Management team meet regularly to review concerns.
- Majority of concerns managed by service support manager/Senior Manager
- Learning, including updating of protocols, consistent application of protocols and case management, shared via the service Quality, Safety and Experience Groups



Background: Patient feedback



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- Thank you cards from our patients to Cataract Outsource provider
- Compliments regarding process, transport & communication



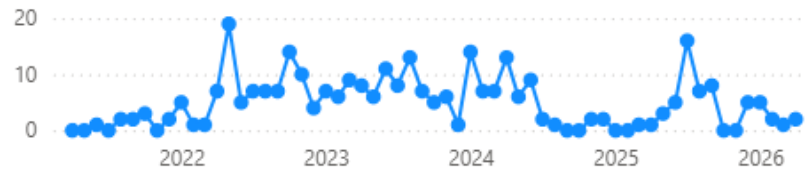
Background: Incidents



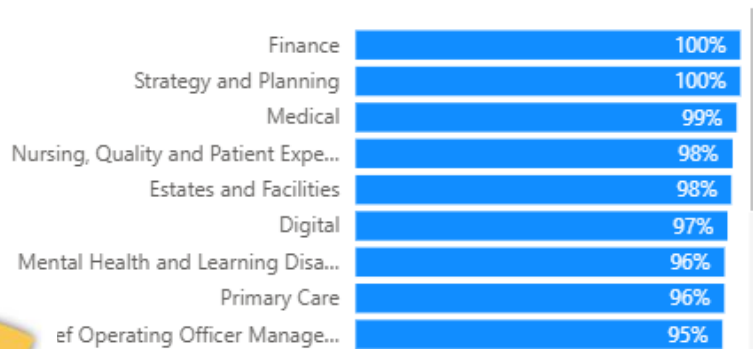
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Incidents by month of occurrence



% reported incidents that have been closed by directorate



- Average of 5 incidents logged per month (between 0 and 19)
- 9 open incidents
- 1 longest waiting incident (237 days)
- During Incident deep dive week (19 to 22 May 2026) 20 incidents closed
- Majority relate to delay in care
- Learning also discussed at local QSE

Open incidents

Press the button below to select the measure you require:



Longest open incidents

Ref	Days open
HDD76650	237
HDD80503	150
HDD81646	120
HDD81968	111
HDD82388	101
HDD83278	80
HDD84419	52
HDD85646	22
HDD86241	7

Service will continue to monitor routinely and participate in monthly targeted incident review process.

Learning will be shared via local governance processes

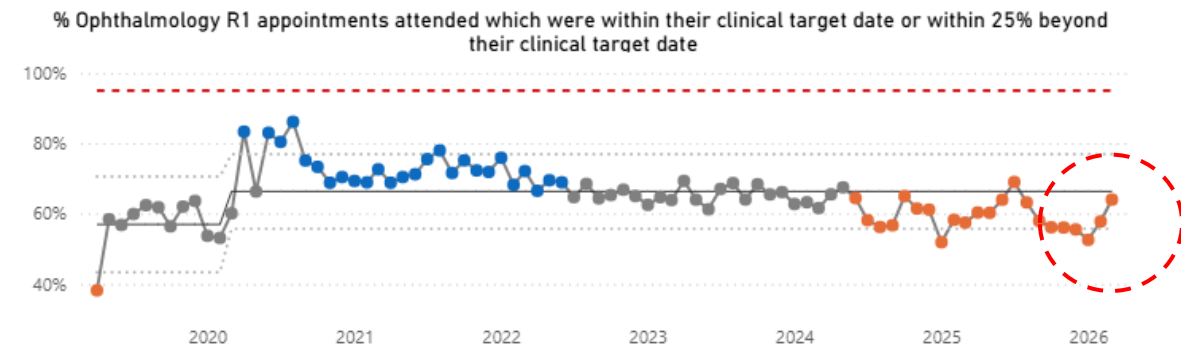
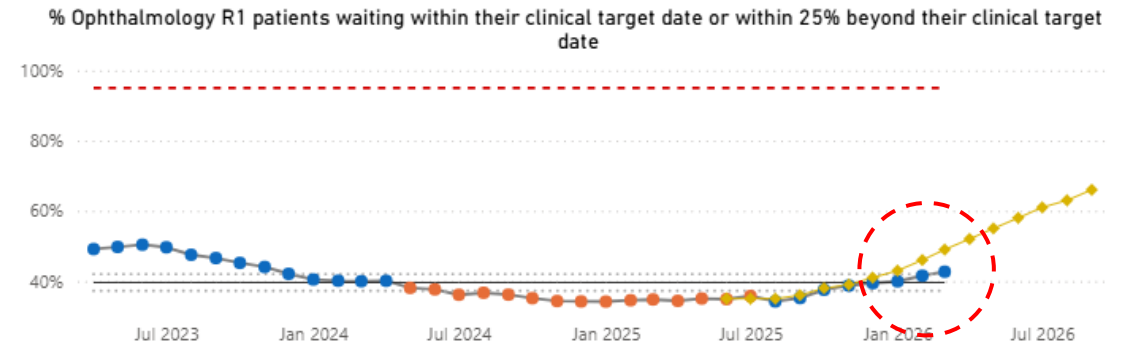
Background: Eye Care Measures (R1 delivery)



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- **Eye Care Measures Target:** 95% patients seen or waiting to be seen are within target date (or 25% of target date)
- **In April 2026:**
 - 62% of those seen were within target
 - 43% waiting for an appointment were within target (or <25%).
 - 7-month consecutive improvement
- Inability to meet target due to challenges outlined on slide 11 and specifically non-emergency patient transport (NEPT) cancellations



Background: Referral to Treatment (RTT)



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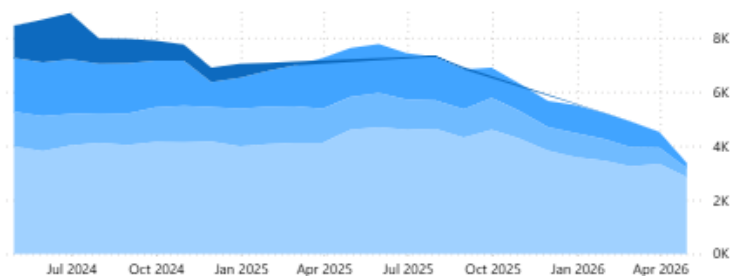
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- **Stage 1 outpatient wait** has reduced from it's highest of 8,915 (June 2024) to 3,368 (April 2026). Recent [HSBUK](#) (Welsh Government initiative has helped this recovery).
- **Stage 3 diagnostic wait** has reduced from it's highest 2,368 (November 2025) to 976 (April 2026). A high volume of this is the correct coding of Cataract patients.
- **Stage 4 treatment waits** have slowly recovered from it's highest (6,538) to 6,029 in March 2026. The rise in April 2026 is partly due to the correct coding of Stage 2/3 patients and the pausing of outsourcing cataract patients (pending recovery funds).

Stage 1

Total patients waiting by length of wait

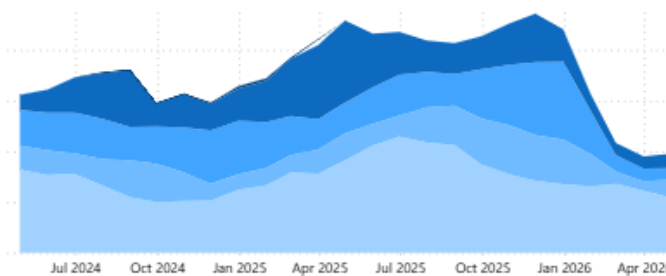
Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



Stage 2/3

Total patients waiting by length of wait

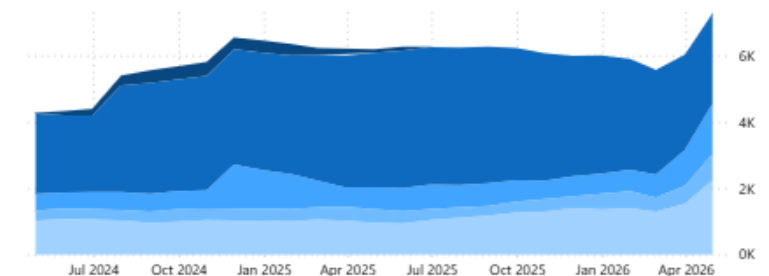
Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



Stage 4

Total patients waiting by length of wait

Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



- Inability to reduce long waits to pre-pandemic levels due to challenges outlined on slide 11 and specially:
 - Pause in Welsh Government Recovery allocation
 - Inflated urgency of patients due to length of wait (i.e., a patient cannot wait 2 years but could wait 36 weeks)

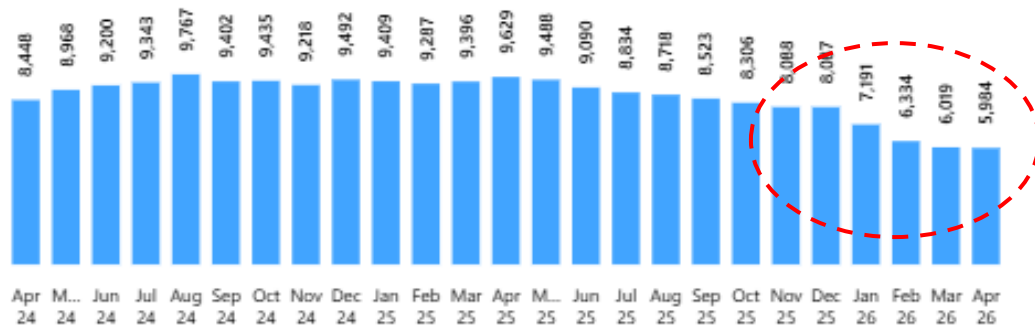
Background: Referral to Treatment



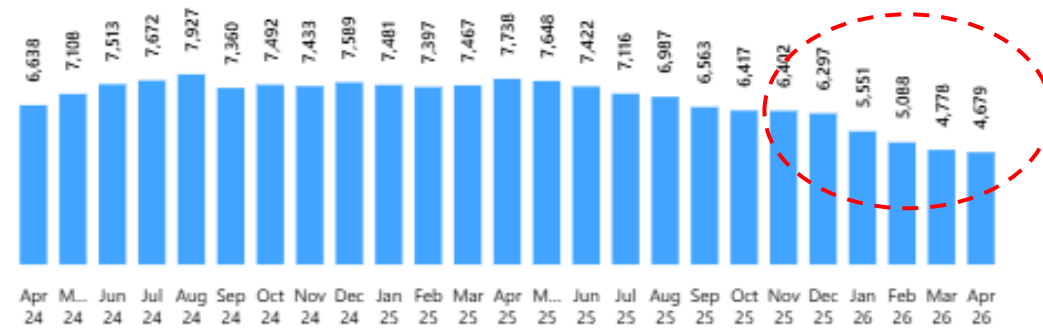
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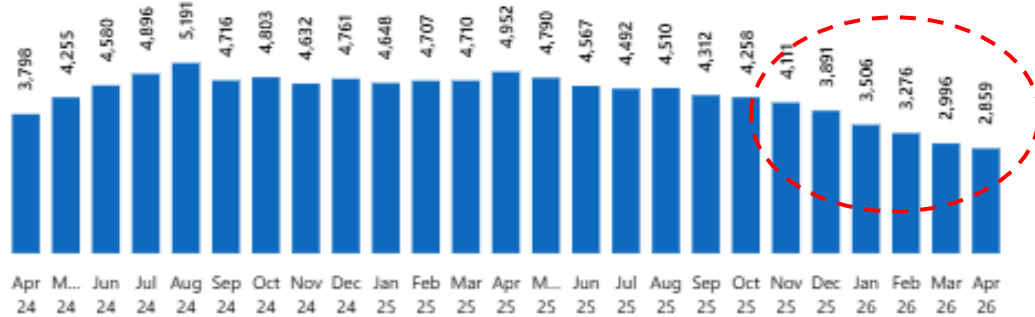
Patients waiting 26 weeks and over



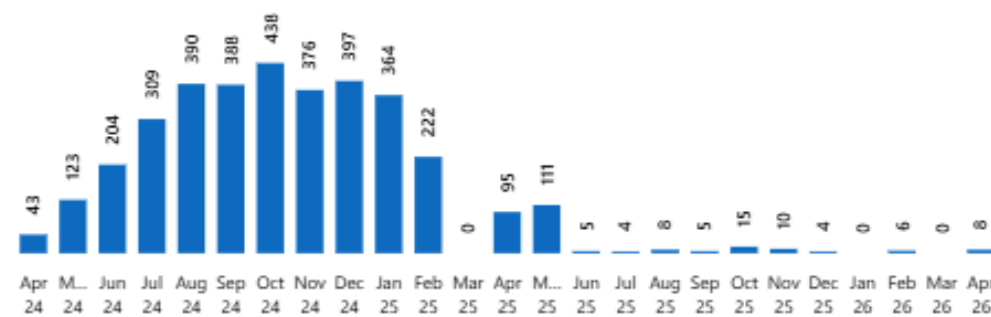
Patients waiting 36 weeks and over



Patients waiting over 52 weeks



Patients waiting over 104 weeks



Despite small volume of patients waiting over 104 weeks RTT in April 2026 the overall breaches for patients waiting over 26, 36 and 52 weeks **has improved**



Background: Follow Up Waiting List (FUWL)



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From April 2025 to April 2026:

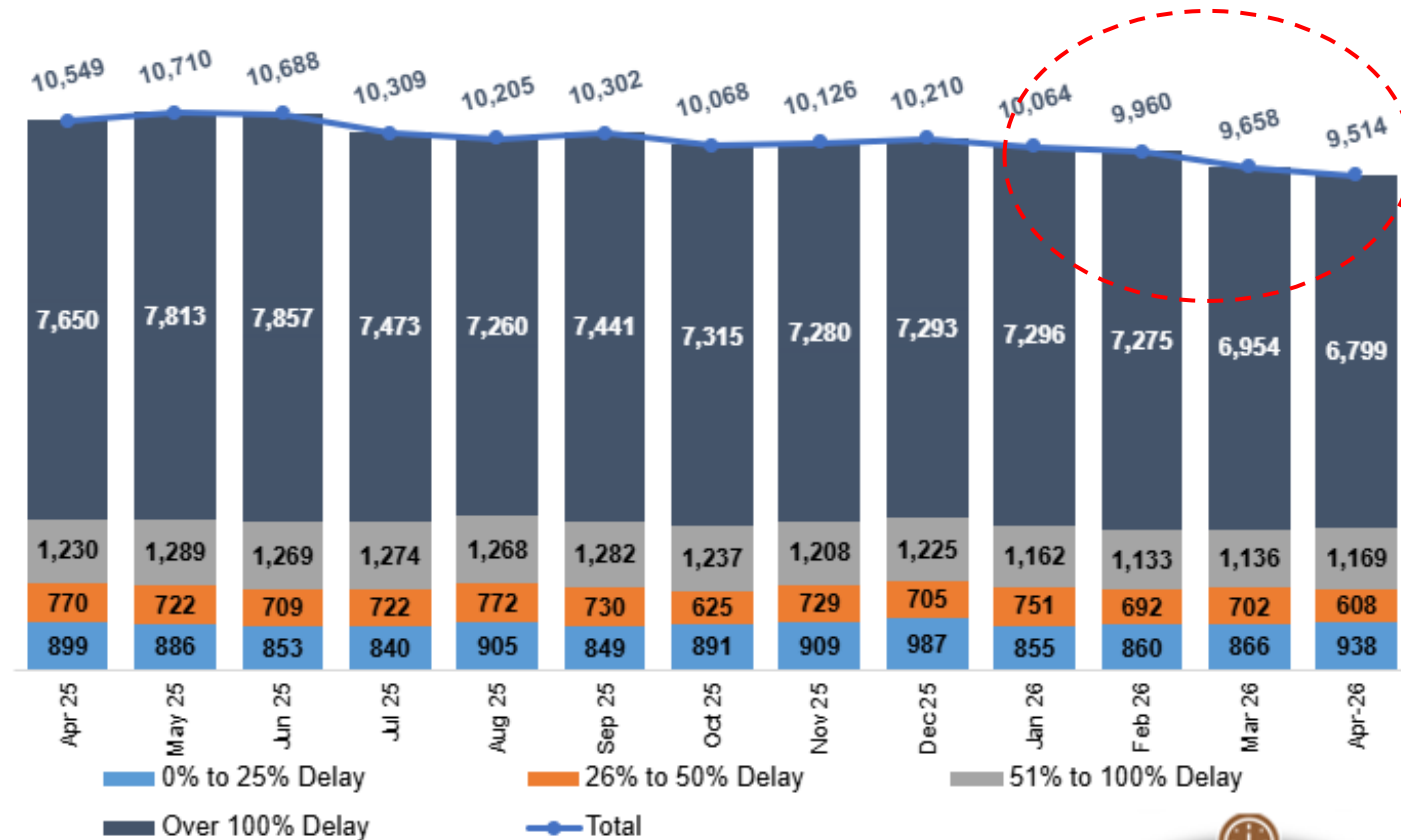
- Total FUWL reduced by 1,035
- 100% delayed reduced by 851

Majority need life-long management (Glaucoma)

Delivery restricted by challenges outlined in slide 11.

Specific challenges include:

- Confidence to discharge, See on Symptom (SOS)/Patient Initiated Follow up (PIFU) (turning off tap)
- Lack of primary care pathway knowledge (Welsh General Ophthalmic Services (WGOS))
- Admin to process WGOS



Assessment: Challenges



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Safe

- High vulnerability during consultant leave or sickness in medical and admin teams
- High volume of sickness due to stress at work
- Estates & infrastructure issues limit ability to undertake activity

Timely

- Post-pandemic long waits reduce ability to provide sustainable services (*patients are marked urgent because they can't wait 2 years, leaving an inflated urgent cohort*).
- Repeated cancellations of Non-Emergency Patient Transport
- Gaps in delivery due to capacity gaps

Effective

- Consultants working single-handedly in subspecialties
- Daily operational issues impede service improvement

Efficient

- Service spread across 8 sites: reducing efficiency, increasing travel costs, limiting training opportunities, and creating equipment variation
- On-call rota (1:6) understaffed, with 3 consultants covering 6 posts
- Equipment availability remains inconsistent across sites

Equitable

- National shortage of ophthalmologists, medical staff, and nursing staff

Person-Centred

- Workforce isolated and working in silos, often without senior support



Patient Story (from AVH not direct)



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81-year-old male treated for Cataracts in AVH (one eye). No family support for transport. Drove to appointment. Had Cataract. Problems accessing car post surgery. Nursing supported. Discovered that patient was intending to drive home. When asked by team why this was (after dangers of driving post surgery had been shared) patient replied ...

“I’m so desperate for my Cataract surgery, no one else could take me. So, I drove myself!



What we are doing: Summary



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Safe



Amserol
Timely



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Effective



Effeithlon
Efficient



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Equitable



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Person centred

- Improving pathway management and validation
- Expanding & reviewing capacity
- Shifting to regional/peripheral models of care
- Increasing diagnostics and virtual review/care
- Improving theatre productivity
- Strengthening workforce
- Maintaining strong governance and performance oversight

**WHAT
WE ARE
DOING**

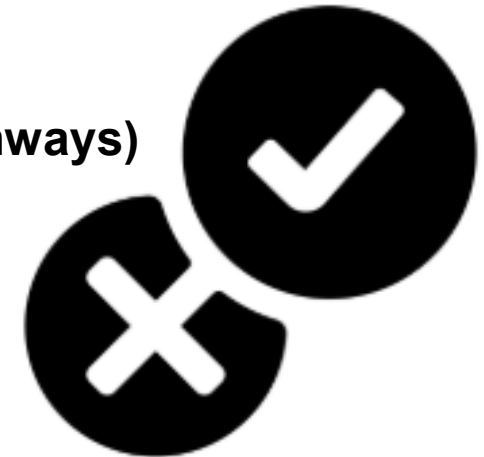
Improving pathway management & validation



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- Ongoing Clinical validation via **non-patient contact desktop reviews**
- Ongoing **clerical validation of waiting lists**
- Increased use of **SOS / PIFU pathways**
 - Clinical condition standard operating procedures written and shared
- Greater use of **Welsh General Ophthalmic Services (WGOS) (primary care pathways)**
 - Community Co-Ordinator vacancy shortly out to advert
- Improving understanding and admin processes for WGOS referrals
 - Additional WGOS training
- Focus on **“turning off the tap”** (appropriate discharge management)



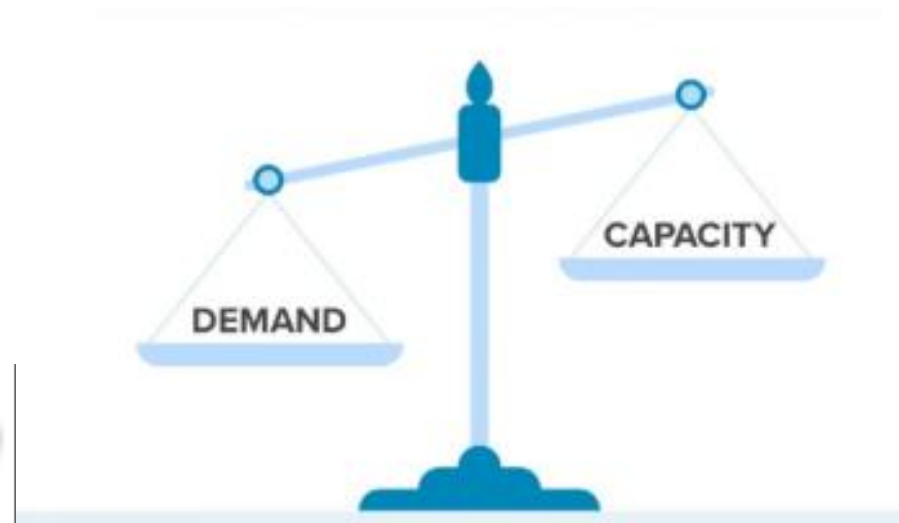
Expanding & Reviewing Capacity



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- Increase clinic activity:
 - New SAS doctors onboarding (1 in Bronglais Hospital (BGH) & 1 in Glangwili Hospital (GGH))
 - Regional consultant Outpatient Department (OPD) activity (Glaucoma x 2 & VR x 1)
- Continue **outsourcing** with recovery funding alongside developing an **insourcing** plan (blended between our consultant & insourcing support)
- Explore High Volume, Low Complexity (HVLC) opportunity in BGH Day Surgery Unit
- Additional intravitreal injection clinics in Amman Valley Hospital
- Overbook high 'Did not attend' clinics to max utilisation (i.e., RACE Follow Up)
- Increase follow-up activity when workforce expands
- Develop Tech support OPD activity to mitigate nursing deficit
- Exploring ability to have **protected patient transport**



Shifting to Regional/Peripheral models of care



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Develop a regional ophthalmology model

To assist recruitment and attractiveness of working in HDUHB



Work with SBUHB for additional clinics and services



Move towards regional on-call model

Shared ROTA for General & VR



Deliver some care at regional hubs instead of local sites



Continue working within Clinical Implementation Networks

Increasing diagnostics & virtual review/care



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- Develop **diagnostic hub (Aberaeron Integrated Care Centre)**
- Expand diagnostic capacity:
 - More **vision lanes**
 - Additional or reconfigured rooms
- Introduce **virtual diagnostic and clinic models**
- Establish **virtual hubs** for review (e.g. glaucoma pathway)
- Enable staff to work at **top of licence** via better facilities



Improving Theatre Productivity



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- Increase capacity via **outsourcing/Insourcing** - cataract, VR and plastics
 - BGH HVLC Insourcing hub being developed
- Review theatre lists to improve **start/finish efficiency/productivity**
 - AVH routinely achieves 8-9 eyes per list
- Continue implementing **GIRFT recommendations (51/59 complete)**
- Expand AVH into a **cataract hub** including 3 session days
- Increase specialist input in theatre lists (i.e., Band 7 Theatre practitioners)



Strengthen Workforce



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- Recruit to other vacant posts across service
- Support Organisational Change Process for admin staff
 - Release 2.4 whole time equivalent (WTE) to Medical Records to do
 - Keep 4 x Band 4 Co-ordinators to manage pathways effectively
- Upskill nursing staff to undertake diagnostic scans / IVT / Triage
- Upskill Optometrists for specialist review, lasers & prescribing
- Develop **emergency eye care practitioners** (Releasing SAS capacity)
- Support SAS doctors to **complete competencies for full rota participa**
 - Laser competence
 - RACE & Discharge confidence
- Invest in **training** and **development** programmes
- (i.e. Advance Nurse Practitioner (ANP) for Nursing)



Governance

- Ongoing monitoring of incidents, complaints and regular Quality & Safety meetings (QSE) to share learning and implement change
- Expand clinical review capacity for complaints (job planning)
- Continue targeted incident deep dive
- Focus on patient feedback and experience improvements



Waiting List / Performance

- Reduce long waits through:
 - Validation
 - Capacity increases
- Improve coding accuracy
- Continue sustained **performance monitoring** and recovery trajectory
- Routine monitoring of DNA Rates
- Use data dashboards (Power BI) to drive improvement

On Call

- Cover rota gaps via additional duty payments (short-term)
- Build sustainable rota via:
 - SAS competency completion
 - Consultant recruitment
- Move to regional out-of-hours model to avoid high spend
- Reliance on out-of-area referrals (e.g. Bristol) should reduce following VR Consultant recruited



IVT

- Continue outsourcing
- Prioritise loading dose & patients with one seeing eye
- Increase injections via additional activity (overtime)
- Develop 5-day IVT service at AVH
- Recruit medical retina consultant (via SB)
- Undertake deep dive Demand and Capacity workshop on 5 June 2026

Any Questions



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- Questions



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RECOMMENDATION



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- The Quality, Safety and Experience Committee is asked to **RECEIVE ASSURANCE** on the current position of ophthalmology services, including the impact of capacity, workforce and pathway pressures on quality, safety, effectiveness and timely access to care.