



Deep Dive: Ophthalmology

Quality, Safety and Experience Committee

December 2025

This report aims to provide the Quality, Safety and Experience Committee with an overview and update on the current state of Ophthalmology service provision across Hywel Dda University Health Board.

- The Committee is seeking to understand the impact of current service fragility within Ophthalmology as part of Clinical Service Plan (CSP) 1.
- How this fragility is affecting service provision, including any associated incidents, complaints, patient experience, and clinical risks.
- The report will outline the interim measures, both in place and planned; to manage these challenges while we await the outcome of the CSP.

This paper outlines the clinical, operational and patient experience impacts of fragility, and the interim actions underway to mitigate risk



The Ophthalmology service within the Health Board is experiencing sustained fragility due to limited infrastructure, workforce shortages and limited out-patient, diagnostics and theatre capacity.

- Limited infrastructure on key sites for delivery, has resulted in the Ophthalmology service working out of 8 sites. This has in time eroded the workforce, who are working in silo, many without senior support.
- The workforce shortages have been driven by a national shortage of Ophthalmologists with difficulty to recruit into consultant vacancies. Consultants are managing their sub-specialities alone, which creates additional fragility when absent due to annual leave or sickness.
- Recruitment difficulties have led to the Consultant out of hours on-call rota of 1/6 currently being covered by four substantive consultants, leaving two gaps in the rota which are covered by additional duty hours. This rota is extremely fragile and is regularly impacted by sickness and annual leave.



Background



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- Both the medical and nursing workforce have faced critical shortages compounded by an inability to support and train staff due to lack of expertise within the service and the service being spread over 8 sites. This has presented challenges to expose team members to learning experiences and progress them to the top of their licence.
- The out-patient and theatre capacity is restricted due to reliance on out-patient and theatre staffing models, and diagnostic delivery is restricted by infrastructure availability.
- The Ophthalmology service is included within CSP to help redesign a foundation on which to build a sustainable Ophthalmology service. A key objective within the CSP is to reduce the sites for the delivery of Ophthalmology, increasing the estates on key sites, to enable staff to work under consultant led care, access the training and experience needed to encourage staff to work to the top of their licence. By reducing the sites of delivery the service will be able to achieve streamlined pathways for patients, reducing hospital visits and improving efficiencies.



Key Messages Overview



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- The Ophthalmology service faces sustained fragility due to workforce and infrastructure constraints, including reliance on other services for out-patient and theatre delivery. This report will examine,
- An overview of R1 (patient at risk of permanent sight loss) delivery through the Eye Care Measures, inclusive of an improvement trajectory.
- An overview of the current position in Ophthalmology for the delivery of the Ministerial Measures.
- A review of the Ophthalmology concerns, raised by patients over a 12 month period.
- A review of the incidents reported over a 12 month period.
- A review of the out of hours on call rota and potential solutions.
- Proposed workforce developments through the annual planning cycle.



Defining a Good Service for the Health Board and Value Contextualisation



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- Improved compliance with Eye Care Measures (to 65% by September 2026), resulting in patients receiving treatment on time reducing risk to a deterioration in their eye sight.
- Improved compliance with the Ministerial Measures (by March 2026), resulting in patients receiving treatment sooner and with better patient outcomes.
- Improved patient experience metrics and continued trajectory of reduced complaints. Better patient outcomes and experience contribute to overall system efficiency.
- Sustainable emergency eye care services improving both patient experience and patient outcomes.
- A stabilised workforce with access to training and support to develop them to the top of their licence and potentially grow them into more advanced roles, further stabilising the service. This will be measured through improvements in the Ministerial Measures, follow up not booked and Eye Care Measures delivery.
- Reduced reliance on outsourcing and ad hoc arrangements.



Short and Long-Term Plans for Ophthalmology



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Short-Term Plan March 2026:

- Validation of R1 patient cohort, supported by the care group to ensure the waiting list is accurate.
- New SAS recruits to undergo competency assessment and for clinic and intravitreal injection clinics to be increased in line with the Eye Care Measures SBAR (Improving R1 delivery to 49% by March 2026).
- Continue to outsource Intravitreal injection patients and cataract patient to maintain current waiting times and to outsource small numbers of Ocular Plastic and Vitreoretinal patients to reduce the risk of harm.

Long-Term Plan March 2027:

- Recruit 2 regional consultants, one for Medical Retina and one Vitreoretinal services, stabilising both sub-specialties and increasing clinic delivery in line with Eye Care Measures SBAR (Improving R1 delivery to 65% by September 2026).
- Establish regional on call service.
- Strategic workforce planning and service redesign under CSP.



Assessment Overview – Key Themes



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Access & Capacity

- RTT performance trends
- R1 delivery
- Theatre constraints
- Diagnostic capacity challenges

Workforce & Service Fragility

- Out of hours on call rota
- Workforce requirements for 2026/2027

Quality & Safety

- Complaints and incident themes

Innovation & Improvement

- Intravitreal Injections Service
- Emergency Eye care Service
- Theatre Delivery
- Outpatient Delivery

These slides collectively demonstrate a clear trajectory of improvement.



Assessment – RTT



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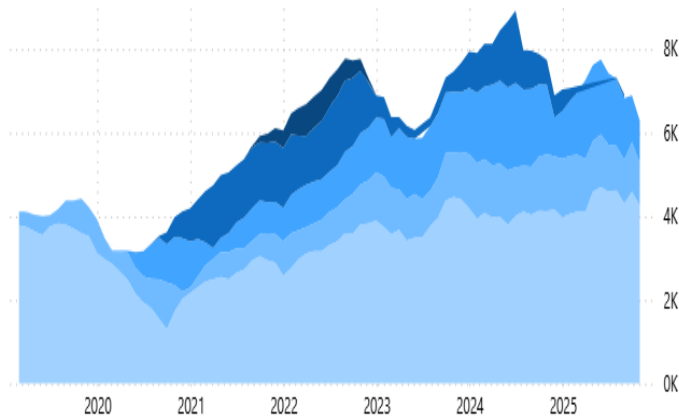
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- Stage 1 outpatient wait for a new appointment has reduced by 965 patients since March 2025 with the longest waiting time being 51 weeks.
- Stage 3 diagnostic wait are incorrectly coded cataracts and has increased by 211 patients since March 2025 with the longest wait being 103 weeks.
- Stage 4 treatment waits have increased by 87 treatments since March 2025 with the longest wait being 108 weeks.
- The below data suggests overall the waiting list for stage 1 to stage 4 has decreased by 667 patients.

Stage 1

Total patients waiting by length of wait

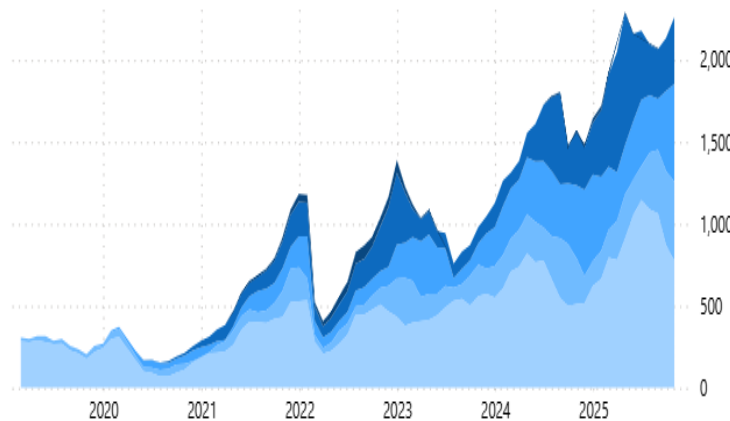
Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



Stage 3

Total patients waiting by length of wait

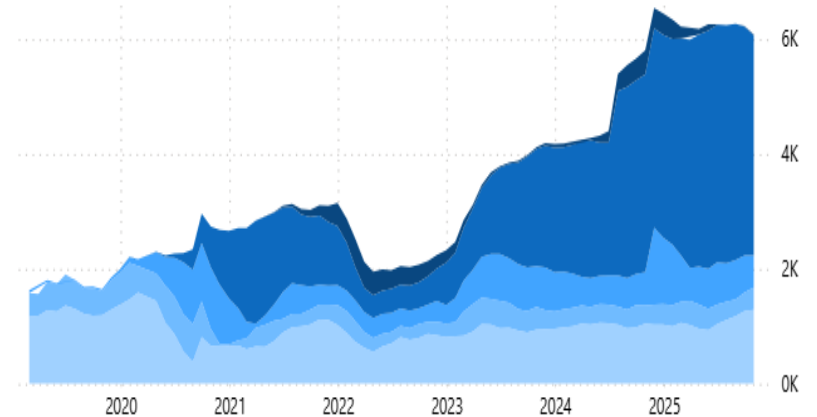
Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



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



Short and Long-Term Plans RTT



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Short-Term Plan:

- Continued administrative validation of waiting lists.
- Continued monitoring of DNA rates to explore further service improvement.
- Continue to increase clinic delivery with the introduction of new SAS doctors.
- Continue with additional WLI.
- Continue outsourcing cataracts increasing delivery externally.
- Continue insourcing to reduce outpatient waiting times.

Long-Term Plan:

- Recruit into two regional consultant positions which will present an opportunity to stabilise the workforce further, increase clinical delivery and bring much needed expertise into the service.
- To continue to work on a regional model which presents a strategic opportunity to deliver high-impact benefits across clinical outcomes, workforce sustainability, financial efficiency, and alignment with wider NHS Wales objectives.
- To continue with the development of the Ophthalmology service through CSP to help redesign a sustainable care delivery and stabilise the service and create a foundation to develop the regional ophthalmology service further.



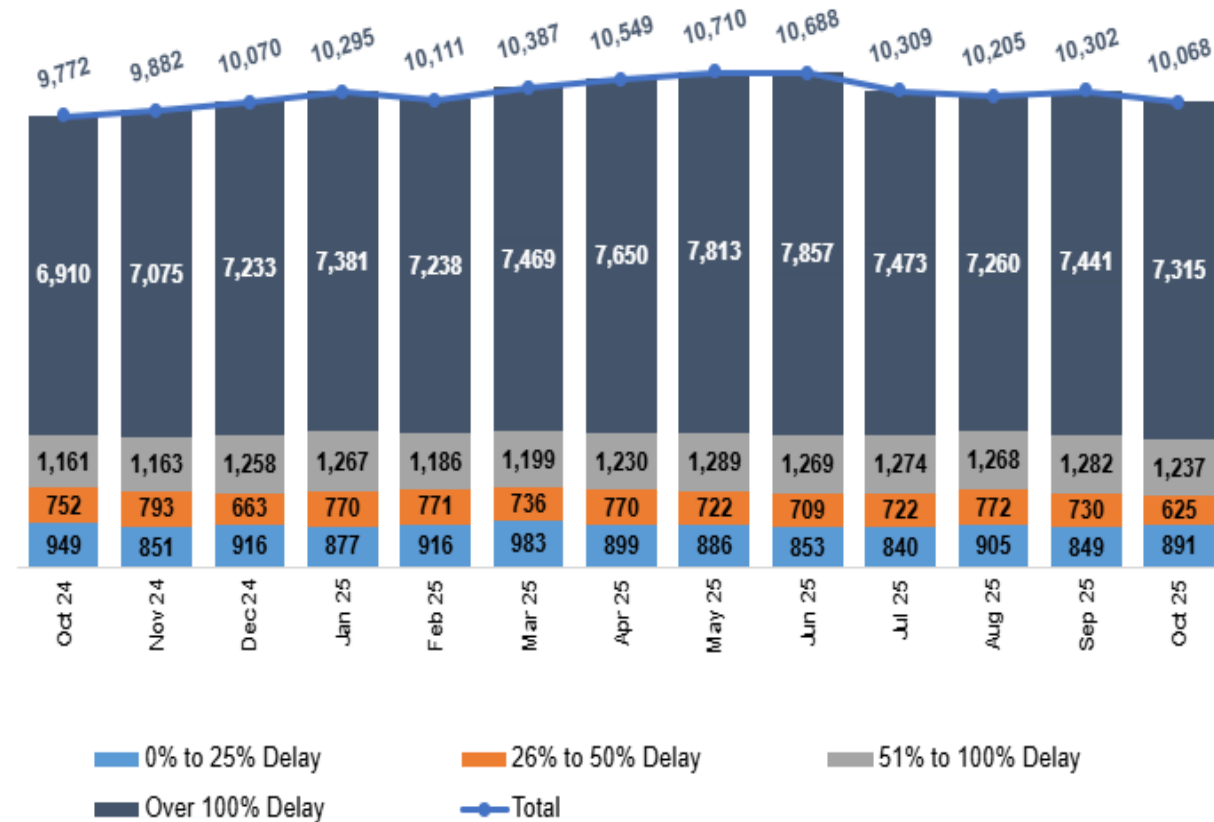
Assessment – Follow up waits



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- Ophthalmology have a high volume of patients on a follow up waiting list that have been waiting for a long time for a follow up review.
- A large volume of patients waiting on this follow up waiting list have a HRF of R1 (high risk), most of these being Glaucoma patients.
- Follow up delivery is restricted by limited workforce. The Glaucoma service is currently supported by a single-handed consultant from SBUHB employed as a part of a regional agreement.
- Clinical validation of this patient cohort is restricted by consultant availability to review, a percentage of these patients could potentially be discharged to the WGOS pathways, an SOS/PIFU pathway, discharged completely.
- Since May 2025 the Ophthalmology follow up waiting list has reduced by 642 patients with 498 of these patients being 100% delayed.



Short and Long-Term Plans for follow up waits



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Short-Term Plan:

- Continued administrative validation, supported by the clinicians where possible. To identify patient for WGOS, SOS, PIFU or discharge.
- Optometrists to continue validating certain sub-specialties to review if patients can be seen on the WGOS pathways any patients who are a cause of concern these are escalated for clinician review.
- WGOS4 pathway management to continue utilising primary care capacity to monitor patients in the community.

Long-Term Plan:

- Continued training of specialist optometrists to ensure the capacity for WGOS pathways can increase in primary care, utilising primary care capacity to monitor patients, where appropriate and safety net them.
- Continue to increase clinic capacity within the service with the development of the Ophthalmology workforce through a regional approach.
- Streamline administrative and clinical processes to ensure robust validation can be developed.



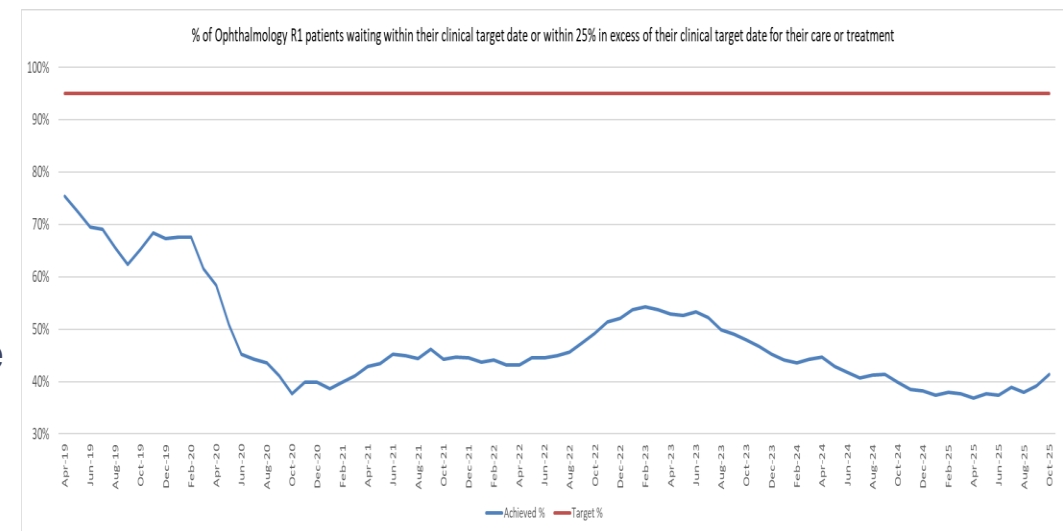
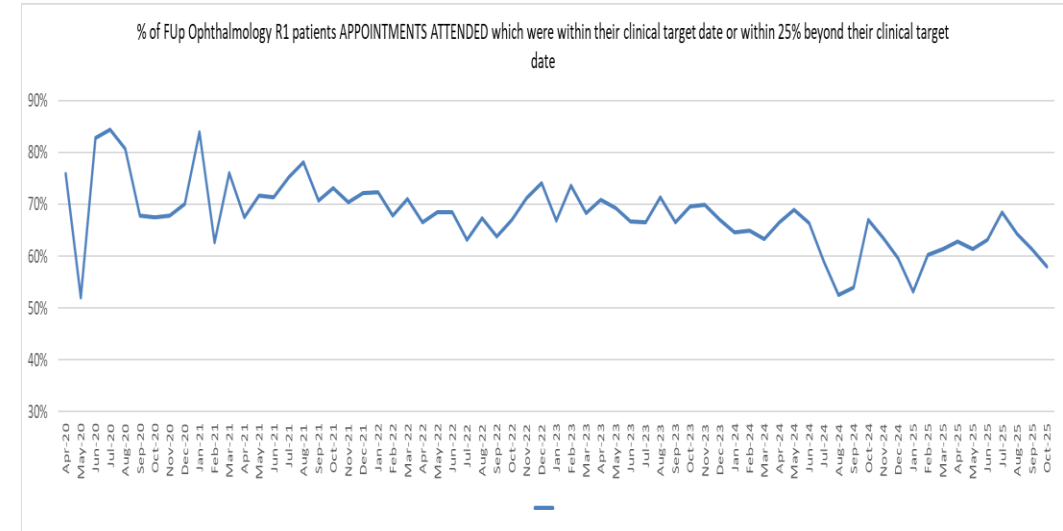
Assessment – Eye Care Measures (R1 delivery)



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- The Eye Care Measures monitors the delivery of timely treatment for R1 patients (at risk of permanent sight loss). There are two targets set by the Welsh Government for delivery of timely treatment for R1 patients both are expected to be at 95%.
- The current percentage for appointments attended 58% and the current percentage for overall waits in Ophthalmology is at 38%
- The delivery for Eye Care Measures (R1 patients) within the Health Board (HB) has been affected by a growing waiting list, recruitment difficulties and service constraints.
- It has been highlighted that there is a deficit both in the workforce and infrastructure to meet the increase in demand in ophthalmology which is impacting on the Eye Care Measures. Short term measures have been taken to stabilise the workforce but further investment in the workforce is required to deliver the necessary clinics and treatments.



Short and Long-Term Plans for Eye Care Measures



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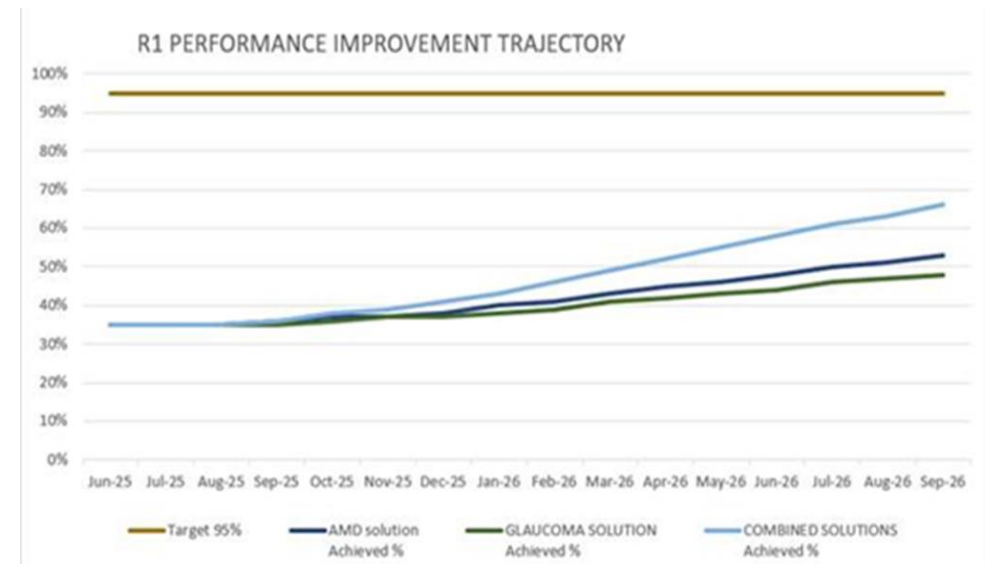
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Short-Term Plan:

- Additional capacity has been secured in the short term through the use of WLI and outsourcing for the IVT service.
- Additional Intravitreal injection clinics have been funded through the annual plan for 2025/2026 and coming online from November through to September 2026.
- Continue to increase clinic delivery through appointed SAS doctors

Long-Term Plan:

- Recruitment of a further two regional consultants will increase both clinic and treatment delivery, improving the waiting list target to 65% by September 2026.
- To develop an Ophthalmology workforce to deliver outpatient capacity in GGH which will deliver a further 11 clinics per week.
- To develop emergency eye care practitioners in line with SBUHB to triage emergency eye care patients and release SAS doctors back to utilise the 11 clinic sessions.



Assessment – Wet AMD Delivery (R1 delivery)



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- The Wet Age-Related Macular Degeneration (WetAMD) patients are a cohort of R1 patients which form 17% of the patients on the Eye Care Measures target.
- These patients are extremely high risk of sight loss if they do not receive their injections on time.
- Currently patients are waiting 6-10 weeks beyond their treatment dates due to capacity within the service not meeting demand. In order to meet this demand, the service would need to undertake 273 more injections per week (13 injections undertaken per clinic).

Number of patients on wet AMD pathway	Number of patients requiring bilateral treatment	Total eyes requiring injection on AMD pathway	Injections required per week for 6 week delivery
2766	602	3368	561
Injections delivered per week	Additional injections delivered through WLI	Total injections per week	Additional injections required per week for 6 week delivery
258	30	288	273



Short and Long-Term Plans for Wet AMD (R1 delivery)



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Short-Term Plan:

- A cohort of 300 patients has been outsourced and this group of patients receives their intravitreal injections on time.
- All patients on a loading dose (3 consecutive treatments) receive their Intravitreal injections on time.
- All patients with sight in only one eye are receiving their intravitreal injections on time.
- Additional capacity continues through the use of WLI running an additional 30 injections per week through AVH.
- Additional Intravitreal injection clinics have been funded through the annual plan for 2025/2026 and coming online from November 2025 through to September 2026.

Long-Term Plan:

- AVH out-patient department needs to be secured for 5 day working to deliver additional Intravitreal clinics.
- The recruitment of a Medical Retina Consultant through the regional consultant posts will increase both clinic delivery and treatments to deliver the 65% R1 delivery by September 2025
- A regional approach has identified the possibility of introducing additional clinics delivered by SBUHB which would be a cheaper option than outsourcing.



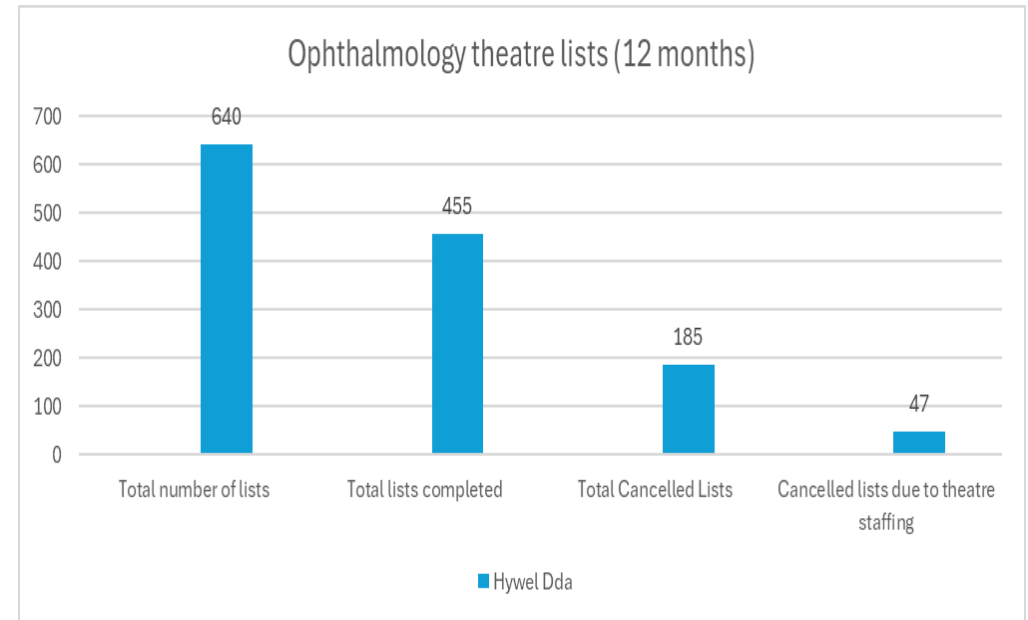
Assessment – Theatre constraints



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- There have been constraints in Glangwili theatre delivery for a period of 14 months due to ongoing staffing issues. This has resulted in Ophthalmology losing service delivery.
- In a 12-month period the service could have delivered 640 theatre lists across site. 455 lists were delivered across site. 185 theatre lists were cancelled. 138 lists were cancelled due to annual leave/sickness. 47 theatre lists were cancelled at short notice due to staffing shortages in theatre.
- Of the 455 lists that have been delivered across site. Only Amman Valley theatre is able to apply high flow principles. This theatre is delivering 7-8 cataract treatments per list. All other theatre lists average at 5 cataracts.
- For the Ophthalmology service to maintain 104 week wait for cataract treatment 3015 treatments are being outsourced during 2025/2026.



Short and Long-Term Plans for Theatre Delivery



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Short-Term Plan:

- Additional capacity has been secured in the short term through the use of outsourcing for cataracts, vitreoretinal and plastic delivery.
- Theatre lists are being scrutinised, reviewing start and finish times to increase in house delivery where possible.
- Getting it Right First Time (GIRFT) recommendations continue to be reviewed with 51 of the 59 recommendations now completed.

Long-Term Plan:

- The annual plan for 2026/2027 will include a proposed Ophthalmology theatre model to ensure specialist input on all Ophthalmology lists.
- Recruitment of one of the regional consultants will increase vitreoretinal theatre delivery within the HB.
- By securing additional days for Intravitreal injections through Amman Valley (AVH) Outpatient department, AVH theatre could be developed into a cataract hub increasing delivery by a further 6 theatre lists.



Assessment – Diagnostic Capacity challenges



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- Diagnostic capacity within the Ophthalmology service is restricted by infrastructure. Each out-patient department is restricted to a single lane for visions and a single room for ophthalmology diagnostic scans to be undertaken, restricting clinic capacity to 30 patients per session.
- The lack of capacity within the infrastructure restricts the development of the nursing, optometrist and orthoptic staff. There are no clinic rooms for them to see patients alongside a consultant and both visions and diagnostic restrictions mean clinic cannot be increased. Without this development and oversight from a consultant they cannot be developed to the top of their licence. If the workforce was developed to the top of their licence this would increase the ability of these staff groups to undertake virtual reviews, thus reducing waiting times.

Short and Long-Term Plans for Diagnostic Delivery



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Short-Term Plan:

- Additional capacity has been secured in the short term through the medical retina consultant undertaking virtual reviews via consultant connect. These sessions could be increased if a second medical retina consultant was secured through the regional programme.

Long-Term Plan:

- A recent regional visit identified where vision lanes and further diagnostic rooms could be developed with some investment in the estates by re-purposing rooms or splitting larger rooms into two lanes.
- A virtual hub could be established in Aberaeron if staff were to be invested in (x1 band 3 technician at a cost of £34,180 per annum).
- Virtual clinics could be developed within the Glaucoma pathway to reduce the burden on face-to-face clinics, if a hub could be secured to undertake essential diagnostic testing (as outlined above).





- The Consultant on call rota is 1:6 currently covered by 4 substantive consultants leaving a gap of 2/6 currently covered by additional hours (ADH) undertaken by staff.
- The fragility of the current service model is as a result of gaps in the consultant workforce. HDUHB currently holds unfilled vacancies for two consultant posts. Historically consultant posts have been difficult to recruit into, largely due to rurality, recruitment competition across Wales, and the absence of a critical mass of sub-specialist support.
- At present, the ophthalmology service operates without any cross-cover arrangements, meaning that when a sole consultant is unavailable due to sickness or annual leave, patients are referred to out-of-area providers (most notably in Bristol for vitreoretinal services). This reliance not only imposes a financial cost of circa £112,791.00 per annum but also introduces delays to patient treatment and travel burdens for patients.
- The SAS on call rota is 1:8 currently covered by 5 substantive SAS doctors leaving a gap of 3/8 currently covered by ADH.

Short and Long-Term Plans for On Call Rota



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Short-Term Plan:

- The gaps on both on call rotas are currently being covered through good will and claimed for through additional duties payment at a significant cost pressure to the Service.
- Three SAS doctors have recently onboarded and are working through their competencies to enable a full SAS out of hours rota to operate.

Long-Term Plan:

- The two regional consultant posts will potentially allow the service to move towards a regional out of hours on call model. This would potentially involve all theatre patients being operated at SBUHB supported by a local SAS on call out of hours service. This will eliminate the need to send patients out of area and reduce costs but also ensure a better patient pathway and patient outcomes.



Assessment – Workforce requirements



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- The consultant workforce will need further investment to ensure single handed workforce models do not continue into the future. There are currently sub-specialities within Ophthalmology that have no specialty consultant, these include adult motility and cornea. These patients are managed under general ophthalmology and transferred to Swansea Bay University Health Board (SBUHB) for further assessment and treatment.
- The nursing model does not allow for the robust development of knowledge and skills within the nursing team. Ideally the workforce model will align with SBUHB which has ophthalmology trained nurses in out-patient and theatre departments managed by the Ophthalmology service giving better training opportunities and opportunities for promotion.
- There are no emergency eye care practitioners in the Health Board, meaning that SAS doctors are utilised to deliver all emergency eye care, where they could be utilised for clinic and treatments.
- The secondary care Optometrists within the service are all employed on a sessional basis.
- There are no Band 8B Orthoptic leads for the HB.

Short and Long-Term Plans for Workforce requirements



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Short-Term Plan:

- To recruit into all vacancies within ophthalmology and invest in training and development where possible.
- To ensure the three SAS doctors have recently onboarded complete their competencies to enable a full SAS team and increase delivery.

Long-Term Plan:

- The annual plan for 2026/2027 will include the required workforce to develop the next phase of the service development. There is a possibility this can be funded from within the current budget but would require a non-pay conversion to pay.

Row Labels	Sum of WTE	Sum of Cost
Band 3 Ophthalmology Outpatient HCSW	3.20	108,777
Band 3 Technician	1.20	40,416
Band 5 Ophthalmology Outpatient nurse	3.20	137,729
Band 6 Eye Care Emergency Practitioner	2.00	105,722
Band 6 Pre-assessment/theatre role	1.00	52,861
Band 7 Service Manager	1.00	65,269
Band 8B Optometrist	1.00	89,366
Band 8B Orthoptist	1.00	89,366
Grand Total	13.60	689,506



Assessment - Feedback and Incidents



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Concerns open

Service	Less than a month	1-3 months	Over 3 months	Over 6 months	Over 12 months	Grand total
Ophthalmology	14	10	3	1	0	28

1 over 6 months - awaiting outcome for patient treatment to determine level of harm

3 over 3 months – 1 delayed treatment requiring further investigation

- 1 unhappy with treatment on ward, awaiting comments from the ward staff
- 1 unhappy about cancellations (response being drafted)

Most concerns over timeliness are managed by the Service Support manager

The Ophthalmology management and clinical team meets every 2 weeks to work through any complex concerns

Assessment - Feedback and Incidents



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Incidents open

Service	Less than a month	1-3 months	Over 3 months	Over 6 months	Over 12 months	Grand Total
Ophthalmology	9	16	7	8	0	40

4 open over 6 months – 3 delay to IVT (awaiting outcome of treatment)

- 4 delay to VR (awaiting outcome of treatment)

-1 Referral delayed (awaiting outcome of treatment)

1 open over 3 months -1 Delay to VR (awaiting outcome of treatment)

-3 Delay to IVT (awaiting outcome of treatment)

-1 Wrong sample (awaiting feedback from consultant)

-2 Prescription error (awaiting IG training certificates)

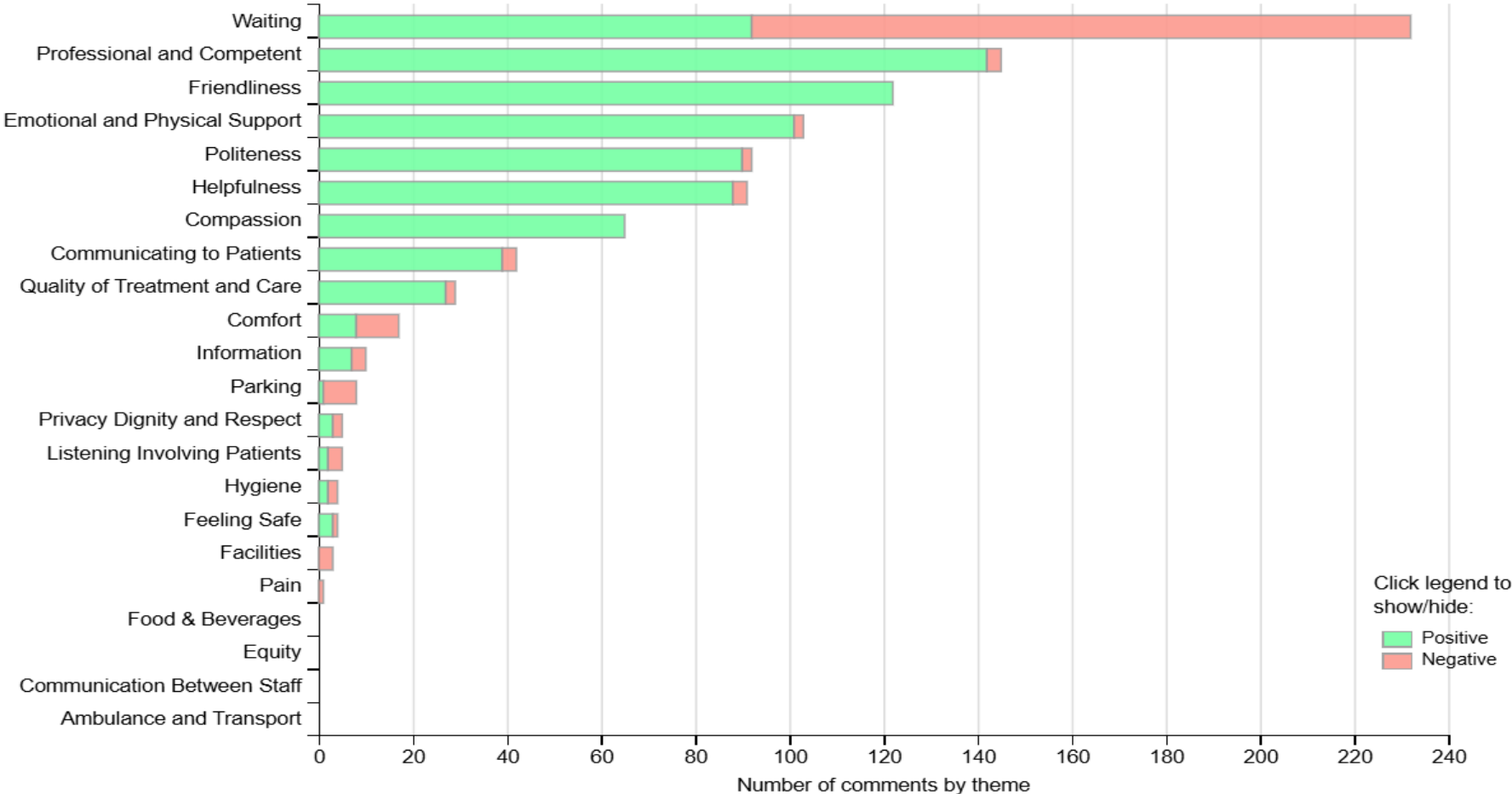
Assessment - Feedback and Incidents



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All Used Categories Pos/Neg Count



Assessment - Feedback and Incidents



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Short and Long-Term Plans for Clinical Governance



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Short-Term Plan:

- To continue to monitor concerns with the support of the concerns team, identifying themes and feeding back to the clinical team through the Quality and Safety meeting.
- To continue to monitor incidents with the support of the risk and governance team, identifying themes and implementing change to reduce the risk to patients feeding back to the clinical team through the Quality and Safety meeting.
- To continue service improvement projects such as the investment in the service for the delivery of Eye Care Measures, which will reduce the risk to patients and improve patient experience.



Long-Term Plan:

- To undertake the annual planning cycle for 2026/2027 to identify further developments needed within the service.
- To continue working regionally to improve service delivery.
- To continue working within the Ophthalmology Clinical Implementation Network to improve patient pathways through networking.



Overall Fragility Scoring following Ophthalmology Review



Criteria	Weighting
Criterion 1: Quality and safety - there is evidence that the outcomes for patients are significantly below comparator providers; or there are significant patient safety concerns; or service does not meet minimum volumes of activity to maintain high standards	4
Criterion 2: Patient experience and performance - there is no viable prospect of the service meeting professional standards, including delivery of timely services	3
Criterion 3: Workforce and culture - the workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed, or retained - or can only be delivered by a dependency on agency or locum staff	5
Criterion 4: There is professional/clinical consensus on the merits of reconfiguring services to deliver an enhanced pathway or a new service model.	2
Criterion 5: There is significant public support or democratic mandate to change a service model.	1
Risk Matrix Scoring: Risk 1664, (score 16)	16
Total Fragility Score	31

Ophthalmology is a fragile service for all the reasons outlined in this presentation. However, the service has made efforts to continue to improve the service where possible and mitigate the risks for patients. The service is monitored against the corporate risk 1664.

Risk 1664 was audited in July 2025 and all actions reviewed, The service has provided reassurance to NWSSP Audit & Assurance team that the fragility of the service is being continuously actioned and monitored.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Related Findings

Assurance

	Objectives	Related Findings	Assurance
1	Controls to address the ophthalmology service issues have been identified, with appropriate actions to address any gaps in control	1 and 2	Reasonable
2	Effective arrangements are in place to monitor performance, action implementation and ensure any barriers to achievement of targets are escalated where appropriate	-	Substantial

The six domains of quality



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Safe

Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce



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Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.



Amserol
Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority



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Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.



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Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.



Person ganolog
person centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.