GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

ADRODDIAD DIWEDDARU'R PWYLLGOR/

SUB-COMMITTEE UPDATE REPORT

LISTENING AND LEARNING SUB-COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 26 March 2026

Quoracy/ Cworwm: The meeting was quorate

Report by/ Adroddiad gan: Eiry Edmunds, Vice Chair

KEY DISCUSSION POINTS AND MATTERS FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Listening and Learning Sub-Committee wishes to **alert** the Quality, Safety and Experience Committee that:

- A detailed update on **Ophthalmology services** highlighted insights from patient experience feedback, complaints, redress cases and external scrutiny. With 793 responses to the patient experience survey, engagement levels were strong. The data showed that while patients were generally very satisfied with the care they received once seen, many experienced considerable anxiety, distress and safety concerns due to long waits,particularly those at risk of losing their sight.

  Complaints data reflected similar themes. Since January 2024, the service received 565 complaints, most of which related to delays in appointments, follow-up, and access to timely care. These delays have affected patient wellbeing and eroded confidence in the service. Complaints tended to fall into two main categories: difficulties in getting patients into the system in the first place, and issues arising during treatment such as pathway pressures and documentation quality. Members were informed that many of these concerns relate to historic issues and that most cases have been managed through Redress rather than litigation, with only a small number of successful claims. The recurring themes emphasise the need for strengthened governance, improved consistency and improve learning across the service.

  The Sub Committee noted that these challenges are occurring in the context of long-standing operational pressures, limited workforce capacity and the vulnerability of a multi-site service model, all areas that have been recognised within the organisation's Clinical Services Plan. The Sub Committee wished to draw particular attention to the significant risks associated with the Ophthalmology waiting list. Nearly 18,000 patients are currently categorised as R1—the highest clinical priority, which without prompt intervention has the

---

[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*

potential for permanent sight loss. Despite active prioritisation and escalation measures, capacity constraints continue to present risk of harm to high-risk patients , posing a significant ongoing patient safety and experience concern.

Two additional clinic days per week are technically available to provide **clinical capacity at Amman Valley Hospital**, with a room and equipment in place however, the space is currently being utilised by other clinics, limiting Ophthalmology's ability to expand delivery. As a result, the availability of physical space does not address the risk associated with the current volume of R1 patients, nor the heightened patient experience impact of continued delays. The Sub-Committee agreed that the inability to fully utilise available infrastructure represents a material constraint on risk reduction.

Advise

The Listening and Learning Sub-Committee wishes to **advise** the Quality, Safety and Experience Committee that:

- A Public Interest Report was issued by the Public Services Ombudsman for Wales following serious failings in the Ophthalmology care of a patient whose right-eye cataract was not reviewed for a prolonged period, despite specialist advice from another health board. When the patient was eventually seen, the review was inadequate: essential tests were not performed, clinical records were incomplete, communication with the patient's GP was poor, and several appointments were cancelled. These failures led to the patient becoming significantly sight-impaired in the affected eye. Given the seriousness of the case, the Ombudsman required a formal apology, financial redress (£4,500 for the lasting impact and £300 for time and trouble), and service-wide reminders to clinicians about reviewing previous correspondence, ensuring timely referrals, and improving clinical documentation. The service has accepted and implemented these recommendations and is awaiting the Ombudsman's formal sign-off.

  Members discussed whether similar risks could affect other patients. While steps have been taken to strengthen documentation, communication and clinical review processes, the Sub Committee was not assured that risks have been fully mitigated, particularly given current service pressures and historically complex pathways. The forthcoming implementation of the Open Eyes electronic patient record system was recognised as an important mitigation, however it is recognised that some residual risk remains.

  Ongoing close monitoring of risk stratification and prioritisation processes for Ophthalmology patients is required. Robust clinical risk-stratification arrangements are in place, with optometrists playing a key role in validating pathways and identifying patients who need urgent escalation. Patients showing signs of deterioration are moved into emergency or expedited pathways to ensure timely intervention.

An update on **Learning from Events and Redress (LFER), Reimbursement from Welsh Risk Pool** was presented, including assurance risks associated with the quality and timeliness of learning submissions to the Welsh Risk Pool. Members noted increasing expectations from the Welsh Risk Pool for clearer evidence of learning, standardisation and impact, and the potential financial and indemnity implications where assurance is insufficient. Concerns were raised about delays in presenting learning, variable quality of documentation across care groups, and the risk of repeated themes not being adequately addressed. The Sub-Committee agreed on the need for a more structured and consistent approach to LFER, including improved governance, clearer panels or oversight arrangements, and stronger evidence that learning is embedded and monitored, to mitigate both patient safety and organisational risk.

Assure[2] (to note)/ Sicrhau (i nodi)

The Listening and Learning Sub-Committee wishes to **assure** the Quality, Safety and Experience Committee that:

The following actions are being taken by the service to mitigate the risks identified above and improve the patient experience for **Ophthalmology Services**:

- Active reduction of the stage one waiting list, alongside targeted work to increase clinic delivery and throughput where possible, with a focus on patients at highest clinical risk.
- Robust clinical risk stratification, supported by optometrists validating referrals and identifying patients requiring urgent escalation, including use of emergency eye care pathways where deterioration is identified.
- Stabilisation of the clinical rota, recognising workforce shortages and the need to maximise available specialist capacity across sites.
- Expansion and scoping of additional laser clinics, aimed at increasing treatment capacity and reducing delays for time-critical interventions.
- Investment in additional staff and equipment, to support clinic delivery, improve patient flow and enhance overall patient experience.
- Implementation of the Open Eyes electronic patient record system, identified as a key improvement to strengthen clinical documentation, communication, continuity of care and oversight across pathways.
- Review and strengthening of governance arrangements for outsourced Ophthalmology care, including clearer consent processes, improved patient information, and assurance of clinical standards following earlier patient experience and complaint issues.
- Ongoing reduction in the stage one waiting list and improvements in intravitreal injection delivery, with evidence of progress reported through service metrics.

Review of Risks/ Adolygiad o Risgiau

---

[2] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

The Sub-Committee recognises the extensive work underway within **Ophthalmology** to manage risk, respond to patient feedback and implement learning from complaints and external scrutiny. However, the scale of the R1 waiting list, constrained clinic capacity (including at Amman Valley Hospital), and the findings of the Ombudsman's public interest report mean this remains an area of heightened risk requiring continued escalation, monitoring and organisational support.

Recommendation/ Argymhelliad

The Committee is asked to:

- **Respond** to the items the Sub Committee is alerting them to
- **Note** the items the Sub Committee is advising them of
- **Take assurance** from the items that the Sub Committee is providing assurance on

Date of next meeting/ Dyddiad y cyfarfod nesaf: 14 May 2026