

GETTING IT RIGHT FIRST TIME

Review of Ophthalmology Cataract and Glaucoma Services

All Wales National Report

October 2023



This report has been produced by the Getting It Right First Time (RNOH/GIRFT) Project Team at the Royal National Orthopaedic Hospital. It aims to reduce unwarranted variation with the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients and to maximise the use of existing resources and assets.

Written by:

Jon Bhargava, GIRFT Ophthalmology National Clinical Lead, Consultant Ophthalmologist Countess of Chester NHS Foundation Hospital

Lydia Chang, GIRFT Ophthalmology National Clinical Lead, Consultant Ophthalmologist Bedfordshire Hospitals NHS Foundation Trust

Melanie Hingorani, Consultant Ophthalmologist Moorfields Eye Hospital

Wojciech Karwatowski, Consultant Ophthalmologist, Ophthalmology Regional Advisor NHSE Midlands

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1. Foreword

The National Health Service faces challenging times in all parts of the United Kingdom. Ophthalmology is the biggest specialty in terms of outpatient demand and an area of particular strain is the provision of glaucoma services, where delayed review can cause irreversible visual loss. Across Wales, there are currently severe and variable delays in glaucoma care.

Cataract surgery is the most frequently performed operation in the whole NHS and waiting times for this sight-restoring surgery are often long, with major negative impact on quality of life, falls prevention and dementia.

To illustrate the challenges faced by all seven health boards, and to set the context of the RNOH/GIRFT visits in terms of cataract services, we have used the Royal College of Ophthalmologists' [Cataract Workforce Calculator](#) to determine the demand for cataract services in Wales. The following data is based upon a [population of 3,210,000](#):

- There will be a requirement for 22,138 cataract operations in the over 50s population in 2023-24 rising to 23,512 in 2028-29.
- This equates to 4084 cataract theatre lists in 2023-24 and 4338 in 2028-29 based upon the current average number of cases on a local anaesthetic cataract list which is 5.42.
- If the case average was to improve to eight cases per local anaesthetic cataract list, the cataract theatre list requirement falls to 2767 in 2023-24 and 2939 in 2028-29.
- Increasing cataract numbers from the average of 5.42 to 8 per 4 hour local anaesthetic cataract list would provide an additional 9,160 cataract slots within secondary care, thus enabling a more flexible and sustainable model of care for years to come. We recognise that a session in Wales is for 3.45 hours, however the numbers should still be largely achievable.

This reduction in cataract theatre lists would not directly address other pressured areas of ophthalmic service delivery such as glaucoma or age-related macular degeneration, which need different approaches in redesigning and optimising clinical pathways, but it would free up clinical staff to potentially support other higher risk areas of eye care. The change principles to improve glaucoma pathways are likely to be applicable to many other outpatient eye care pathways, particularly long term sight threatening conditions.

By addressing and delivering our recommended improvements in the two highest volume ophthalmology pathways in Wales, the surgical pathway for cataract and the long term outpatient care pathway for glaucoma, we believe Wales has a significant opportunity to develop and deliver a high quality, holistic and equitable eye care service to patients within which the multidisciplinary workforce and ophthalmic surgeons of the future can be developed.

We fully support the establishment of a National Ophthalmology Strategy which is in development. The development of this strategy should take into account the various recommendations we have made in this report.

Mel Hingorani, Jon Bhargava, Lydia Chang, Wojciech Karwatowski.

September 2023

2. Executive Summary

Getting It Right First Time (GIRFT) is a national programme in England developed by the GIRFT national team under the chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice.

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the chairmanship of Professor Tim Briggs, was commissioned by the Planned Care Improvement and Recovery Team (PCIR) to undertake a review of the provision of ophthalmology services across Wales, concentrating on the most common operation, cataract surgery, and a high volume chronic outpatient condition, glaucoma.

This report is based on the data and observations from RNOH/GIRFT's visits to all Welsh health boards to review the glaucoma and cataract care within their ophthalmology services. We have separately undertaken a review for Betsi Cadwaladr University Health Board (BCUHB) which was commissioned prior to this all Wales review. The observations from all our visits (including BCUHB) are reflected in this report.

The RNOH/GIRFT team undertook on-site visits to view facilities, speak informally to staff and observe the cataract pathway in action. In addition, we undertook deep dive data reviews either on site for cataract (the majority) or remotely (glaucoma and some cataract). The table in Annex A shows the schedule of the visits.

We observed variation in practice, as well as variation of availability of key data to confirm practice standards, within health boards, between health boards, and when compared with NHS England ophthalmology metrics. Due to the standard of coding and gaps in data collection (particularly for outpatients) for ophthalmology services across Wales, the GIRFT ophthalmology data pack metrics were not always of sufficient quality for us to make detailed comments about performance and variation. We did, however, learn a lot from the engagement with health board staff and observing practice during our on-site visits and received updated or more granular data during the visits to supplement the data packs. We have found multiple opportunities for improvement. Local staff had already identified many of these and were keen to take them forward but had struggled to progress the changes. Where we have observed unwarranted variation or missed opportunities, we have challenged the ophthalmology teams and their executive leaders. RNOH/GIRFT has issued a report to each health board recommending a series of changes to improve care for patients.

Overall, we found significant unwarranted variation in the way patients are treated and therefore in patient experience and outcomes. This is not helped by hospitals and health boards continuing to largely work in their own silos and not sharing good practice or working in regional networks. We found health boards in which there are unsafe delays of several years to review glaucoma, with a risk of permanent but avoidable visual loss in many patients; and areas where patients are waiting an unacceptably long time for sight restoring cataract surgery.

Some health boards simply cannot attract enough consultants, leading to patients being managed without consultant oversight, inadequate capacity to treat patients, and a lack of clinical leadership time to drive improvements. We identified some excellent practice in Wales, which needs to be cascaded more widely to enable all health boards to benefit. We have made a series of recommendations in this report which aim to tackle waiting lists, improve structures and ways of working, and improve quality of care and governance of ophthalmology services

across Wales. It is imperative that the NHS in Wales now works together to implement these changes and do so swiftly. During this project, we have been repeatedly made aware of various reports and action plans over the last 15 years on ophthalmology which have not translated into delivery of the changes identified. It is now essential that the recommendations made in this report are immediately taken forward to put in place a structure and ways of working across Wales to rapidly deliver real action - to improve care for patients, avoid multiple cases of permanent visual loss through delays, create and retain the correct workforce, and to avoid costly short term solutions which risk becoming embedded to the detriment of NHS services. This will involve the health boards working together across their historical boundaries, in regional and, in some cases, national networks of care, and targeted investment to ensure a smaller number of ophthalmology outpatient and surgical centres with excellent facilities and enough activity to create a critical mass in each region. We have made 10 national recommendations in which change is best done once nationally or only achievable with a national approach. The other national recommendations relate to how NHS Wales can support the implementation of our recommendations which are to be delivered by health boards, as many improvements required apply to all health boards. We have provided a number of useful links to GIRFT and Royal College of Ophthalmologists' good practice in Annex B.

Finally, and possibly most importantly, a message to national leaders, executives and senior management who oversee ophthalmology services. Ophthalmology is different from other specialties. It is hugely important that you work with your ophthalmic teams to properly understand this report. We have seen some units in the UK use the high volume numbers on a local anaesthetic (LA) cataract list recommended by RNOH/GIRFT to criticise their teams, without comprehending that we also say this needs time and resource, such as clinical leadership, staffing, suitable facilities or permission to deviate from generic theatre processes. Sometimes there is incorrect extrapolation of recommendations meant only for LA cataract lists, for example removal of the anaesthetist from all ophthalmology lists, so that non-cataract surgery is threatened. This demotivates and demoralises the ophthalmic team and will inhibit improvements. It is crucial that managers and executives support and change **with** their ophthalmic team, not impose change without understanding the issues.

Mel Hingorani, Jon Bhargava, Lydia Chang, Wojciech Karwatowski, Clinical Leads.

September 2023

3. Summary of Recommendations

NO	NATIONAL RECOMMENDATIONS
1	Welsh Government with health boards to fund and appoint more consultants, develop a plan for and advertise the factors that will attract them e.g. Investment, good facilities, a clear commitment to improvement, regionalisation, educational and professional development opportunities, academic opportunities. NHS Wales to ensure that existing and new consultants have enough protected service improvement and clinical leadership time in their job plans to enact the required local recommendations – if necessary, through more funding.
2	Health Education Improvement Wales (HEIW) and ophthalmology leaders should continue to explore strategies aimed at improving recruitment and retention of trainees'.
3	NHS Wales to ensure that ophthalmology is properly prioritised at local organisational level so that chief executives and other key leaders in health boards provide the ophthalmic clinical and management teams with the support they need. NHS Wales to ensure health boards provide enough senior service management and project management support to implement the changes.
4	NHS Wales to ensure effectiveness of regional working to move patients or staff as necessary to use current resources and capacity most efficiently and to equalise waiting times within and across health boards for cataract, glaucoma and other eye care.
5	NHS Wales to promote regional cross-health board ophthalmology services with appointments to the region not individual health boards, managed as a whole regional ophthalmic MDT. Health Boards making up regions need to ensure there are resourced regional ophthalmology transformation teams to develop and deliver the new regional services.
6	Welsh Government to rationalise and reconfigure all ophthalmic services to establish fewer suitable sites with a critical mass. Invest as required into existing or new facilities, to create surgical hubs, outpatients, ODTCs and larger high flow technician-led diagnostics and MDT virtual review sites, fit for modern ophthalmic care. Take into account the longer-term rising population demand for care, on site delivery of training for the MDT and primary care optometrists, geography and travel/access.
7	<ul style="list-style-type: none"> - DHCW / Welsh Government to urgently accelerate the development and implementation of the OpenEyes national ophthalmic EPR and electronic referral system, within all hospital eye services, in ODTCs and in primary care optometry, and in doing so: Ensure health boards have support and resource to implement not only technically, but also in terms of change management, engagement with and support for clinicians using the systems. - Ensure there is enough technical and non-technical manpower and revenue as well as capital resource. - Prioritise the key subspecialties and develop in the same order in each health board so that mutual learning can occur. Ensure the “big 4” subspecialties are prioritised i.e. cataract, glaucoma, medical retina and urgent/emergency care.

	<p>Consider starting with cataract which is the simplest to implement and has instant benefits for clinicians.</p> <ul style="list-style-type: none"> - Include in the OpenEyes funding suitably good grade and high spec dual screen PC's for more effective and rapid clinical decision making by the MDT.
8	Health Education Improvement Wales (HEIW) to work with NHS Wales to lead a task and finish group to review opportunities to strengthen multi-professional working across the eye care pathway identify appropriate education and training pathways.
9	NHS Wales to continue to ensure that ophthalmology is prioritised at national level and to support and accelerate the ongoing development of the national ophthalmology strategy with rapid implementation of the changes agreed in this.
10	NHS wales should ensure that the CIN works with health boards to develop a set of key metrics for ophthalmology which should then be rolled out to health boards to measure and report against.

ALL HEALTH BOARD CROSS CUTTING RECOMMENDATIONS	
11	NHS Wales to support and encourage all health boards to set up appropriate Ophthalmology governance within their health board (which may be a Steering Group or Task and Finish Group) to ensure that health board recommendations are implemented and embedded, along with any other improvements the health board identify themselves. This group should have strong links with any regional ophthalmology steering group. We recommend that these are established without delay.
12	NHS Wales to support and encourage all health boards to review the ophthalmology line management structure and explore whether an MDT cataract or whole ophthalmology team across all areas (outpatient, day case, theatres, pre-op, imaging) dedicated to ophthalmology will work better. Consider whether to use staff more flexibly across these different areas e.g. using clinical nurse or optometry specialists in theatre or day care. Provide dedicated, stable and senior enough ophthalmology service managers.

ALL HEALTH BOARD CATARACT RECOMMENDATIONS	
13	NHS Wales / Welsh Government to support and encourage all health boards to ensure they work closely with local primary care optometrists providing feedback and communication, and create ways to ensure high conversion rates and good post-operative data return which is fed into records and audited.
14	<p>NHS Wales to support and encourage all health boards to improve pre-operative assessments for cataract surgery:</p> <ul style="list-style-type: none"> - Do all cataract pre-ops as a one stop, even GAs and complex cases, especially for patients living far away. Adopt a national 'normal practice' pathway for one-stop clinics to address varying practice. - The whole pre-op attendance needs to be reviewed and the team given the resources they need (e.g. space, enough trained MDT staff, a consultant with enough slots to see all the patients briefly, with everyone working to the top of

	<p>their license) to ensure an efficient and robust one-stop pre-op assessment is done within a short timescale (no more than 3 months) to surgery date.</p> <ul style="list-style-type: none"> - Use hospital optometrists and nurses to undertake phone calls to screen out patients who don't need surgery and to counsel and pre-populate pre-op assessment documents for those who do go ahead. Add e-consenting signatures or even send the consent form by post. - Expand the staffing and the remit of the MDT in pre-op assessments, with technicians and HCSWs doing more of the routine workup and biometry, and practitioners including nurses, orthoptists and optometrists able to undertake the slit lamp and fundal checks and consent; obtain IOLMaster 700s to support a wider range of staff to undertake biometry.
15	NHS Wales to support and encourage all health boards to offer ISBCS to all suitable patients.
16	NHS Wales to support and encourage all health boards to introduce standardised risk ratings in line with College guidance for cataract surgery recorded on waiting list forms and to identify suitable patients for HVLC lists.
17	NHS Wales to support and encourage all health boards to create a protocol on managing co-morbidities for LA cataract surgery based on GIRFT/RCOphth guidance, simplify relevant pre-op- and on the day of surgery documentation in line with this, and train staff to implement.
18	<p>NHS Wales to support and encourage all health boards to increase the number of patients on a LA cataract list:</p> <ul style="list-style-type: none"> - Do LA cataracts on cataract only lists. Use high flow processes for patients of ANY complexity. - Start to undertake HVLC lists with lower complexity patients or build on existing pilots: <ul style="list-style-type: none"> o Consider removing trainees for some HVLC lists at the beginning, to "prove the principle", then roll out the learning and incorporate trainees, to ensure they learn to deliver within HVLC lists (any removal of trainees needs to be considered in conjunction with HEIW). o Organise HVLC list pilots alongside a more complex list, if two theatres are available, to allow anaesthetic support for unstable patients and/or take over the patient if any unexpected complications occur and to test the waters. - Agree more cases per list and do not finish early routinely or take a leisurely approach. Patients are waiting a long time for sight restoring surgery and this must drive everyone to operate efficiently and optimise surgical time. If high volume surgery with high numbers are achieved, early finish should be acceptable as a bonus to teams who achieve this.
19	<p>NHS Wales to support and encourage all health boards to improve on the day of LA cataract surgery experience and efficiency:</p> <ul style="list-style-type: none"> - MDT trained and empowered to mark the eye, check or take consent etc. - Eliminate surgeon pre-op ward rounds for LA cataract lists. Consultants only check notes and greet and reassure the patient, ideally in the anaesthetic room. - Ensure the admission area to be suitable, avoid queuing patients in the corridor and eliminate any unnecessary Covid tests.

	<ul style="list-style-type: none"> - List order and details MUST be agreed before the day and have a “golden patient” listed first. - Use pellets for pupil dilating (unless the patient has performed self-dilatation) and not drops. - Consultant job plans and staff rostering to be arranged to allow lists to start on time and a move from 3.75 hour lists to LA cataract lists to longer lists where possible.
20	<p>NHS Wales to support and encourage all health boards to improve turnaround times in LA cataract lists:</p> <ul style="list-style-type: none"> - A member of the MDT should send for the next patient routinely at an agreed point in the current case, without having to be told do so by the surgeon. - Use the anaesthetic room for the LA to be given and patient positioned on the trolley. Wheel the patient in and out of the operating room on the trolley or couch. - Undertake the instrument count in the last few minutes of the case. - There should be a standard cataract operation note template and the note should be pre-populated by the MDT.
21	<p>NHS Wales to support and encourage all health boards and regions to optimise use of current surgical facilities for LA cataract:</p> <ul style="list-style-type: none"> - In the most suitable eye theatres, use the fallow sessions and move other specialties out, to run more eye lists. Consider long days or 3 session days, 6 day working week and avoid short (3.75 hour) lists to optimise use of the facilities. Start lists earlier and ensure job plans and rosters accommodate all these changes. - Equalise waits across sites, and shift patients to where the capacity is within the health board or region. - Urgently scope changing the facilities provided in Royal Glamorgan Hospital, Abergele and Glangwili, to provide a safer day case area and theatre much nearer to each other. If improvements not possible, care should be moved to other units. - Sort out any basic logistics of the stock checks and replenishment, HSDU, storage etc. as soon as possible.
22	<p>NHS Wales to support and encourage all health boards to improve the utilisation of the non-medical MDT on the day of surgery:</p> <ul style="list-style-type: none"> - Undertake a whole MDT workforce review, pushing everyone to the top of their license and assessing numbers and training requirements for cataract and HVLC - MDT staff trained and empowered to routinely prep the skin with iodine, apply the drape, insert speculum, position microscope for surgeon, draft the operation note, print the op note/letter/discharge medication. - Where cost effective, use more nurses or other MDT staff to accompany the patient around the whole on the day journey to achieve higher list numbers. - Accelerate the training and improve career ladder of scrub practitioners who are HCSW’s including through the national workforce project (recommendation 8). - Use the Modelling software available RCOphth cataract workforce calculator (RCOphth cataract workforce calculator tool The Royal College of Ophthalmologists).
23	<p>NHS Wales to support and encourage all health boards to:</p> <ul style="list-style-type: none"> - Move to topical anaesthesia as a default for all suitable cases.

	<ul style="list-style-type: none"> - For patients who need blocks, train other staff e.g. nurses, ODP, physician assistant, to administer blocks. - If using a subtenons block, the block must ALWAYS be done early enough and whilst the previous case is in being operated on, so that the patient is ready to come into the operating room with no delay. - Cease the routine use of the anaesthetist in LA cataract lists and agree a pathway with other anaesthetists or ambulance service to cover the occasional unwell patient.
24	<p>NHS Wales to encourage and support all health boards to improve cataract record systems:</p> <p>Review the documentation for LA cataract surgery against the GIRFT guidance and example booklet, remove all unnecessary data collection and incorporate all relevant documents into one lean booklet which supports the new processes. This is urgent in areas where there is excessive and generic paperwork.</p> <p>Review the use of TOMS and consider an improved system across these health boards. Whilst TOMS is in use, use a tablet to enter the data so the system does not pull staff away from patients.</p>
25	<p>NHS Wales to support and encourage all health boards to improve clinical governance:</p> <ul style="list-style-type: none"> - Ensure regular internal cataract audits are done looking at PCR AND visual loss for the whole unit and individual surgeons and support with audit and admin staff as necessary. - Use the audit sessions to join up the WHOLE cataract / ophthalmology pathway team including theatre staff to review processes and performance and drive improvement. - Undertake regular observational audits to measure and monitor the flow in cataract lists.
26	<p>NHS Wales to work with health boards to establish a national vitreoretinal service.</p>
27	<p>NHS Wales to support and encourage all health boards to reduce patient journey times:</p> <ul style="list-style-type: none"> - Establish staggered patient arrival times and ensure patients have pre-packaged standardised post-operative drops which can be dispensed in the day care area. - Where not already doing this, undertake a pilot of patient self-dilating and, once the process is established, roll out to all suitable patients. Where patients need dilating at the hospital, use a pellet not drops.
28	<p>NHS Wales to support and encourage all health boards to improve patient consenting:</p> <ul style="list-style-type: none"> - Consent must be taken before the day of surgery. Consider supporting the primary care optometrists to do more and share the consent form. Consider posting the consent form out to patients in advice, nurses and optometrists in clinic to be trained to consent. - Use an appropriate cataract specific consent form similar to the RCOphth consent form, which is approved by the major patient charities as accessible. - Consent patients for both eyes at the first eye pre-operative visit. Consent by phone for second eye if already on list and post consent form out to read +/- sign

	at home or use e-signature
29	NHS Wales to support and encourage all health boards to reinstate GA cataract surgery in all suitable facilities and use capacity across and between health boards to equalise waiting times. Consider using a Friends and Family list approach for patients with particularly complex needs.

ALL HEALTH BOARD GLAUCOMA RECOMMENDATIONS	
30	<p>NHS Wales to support and encourage all health boards to improve ODTc performance:</p> <ul style="list-style-type: none"> - Increase the numbers of patients seen per session in ODTcs; review and reduce any unnecessary Covid specific infection control practices. - Increase the numbers of patients seen per session by adopting a two stop pathway, separating face to face diagnostics (tests) from the clinical review activity, with the review done later by a MDT clinician or ophthalmologist. - Ensure tests are done by technicians, HCSW's and assistants where possible in all settings, ideally in layouts which support high flow, freeing up the clinicians to be clinical decision makers. - Ensure accurate data (including the discharge rate) is regularly reported on the performance of primary care referral filtering as well as the ODTcs to drive improvements.
31	<p>NHS Wales to support and encourage all health boards to reduce risk and use current resource better for glaucoma patients:</p> <ul style="list-style-type: none"> - Ensure a consistent risk stratification is used for every glaucoma visit, at all sites and for all types of visit, including the greater care in optometry as the contract changes. Use this to create a view of the whole patient population as high, medium & low risk. This should be addressed straight away. - Standard operating procedures, protocols and guidelines for glaucoma should be created and include clinical risk criteria for patients, the specific steps of the operational processes and the pathways, and the clinical decision making and associated governance supporting this. - Implement more diagnostics only clinics with technicians and HCSWs, with later review by the MDT clinical decision makers whether in hospital or ODTc.
32	<p>NHS Wales to support and encourage all health boards to improve use of existing estate:</p> <ul style="list-style-type: none"> - Explore the use of asynchronous virtual clinics with written confirmation of results to the patient or, if more appropriate, with remote video or telephone consultations after diagnostic data collection. Do the virtual reviews in non-clinical rooms as long as the clinicians can access the notes and diagnostics/imaging data. - Review the footprint and usage of all the current and potentially available new space in outpatient areas and create subspecialist areas with teams and all equipment in one area for glaucoma. - Improve the facilities, access and parking of the eye units where possible. Sort out the décor and repair within current facilities. Support the staff to reassess and improve the space use; remove extraneous equipment and extraneous staff and

	tasks from small spaces.
33	NHS Wales to support and encourage all health boards to audit their glaucoma practice and see whether patients are being overly followed up, not discharged or not managed well, to inform any business case for more consultants or other practitioners to replace them.
34	NHS Wales to support and encourage all health boards to undertake a comprehensive review of the roles, job plans, the numbers and professional development of the MDT, in the glaucoma services in hospital and the ODTs. Utilise the capabilities of non-medical staff to the maximum so that the consultants can concentrate on the complex cases, training and service improvement.
35	NHS Wales to support and encourage all health boards to reduce unsafe delays and improve glaucoma capacity: <ul style="list-style-type: none"> - Accelerate as much as possible the efficiency and staff changes required, using the recommendations in this report, to eliminate the glaucoma backlog earlier than 2025. - The very long waiters need to be assessed now (e.g. by virtual assessments) regardless of the original risk rating to avoid avoidable cases of serious harm. - Urgently address ensuring the data for glaucoma activity and delays are accurate and rapidly introduce regular validation processes. - Urgent capacity and demand work for the current glaucoma backlog, with an honest assessment of the situation, and production of a strategic demand and capacity, workforce and funding plan to attain a sustainable model for glaucoma services.
36	NHS Wales to support and encourage all health boards to appoint a dedicated failsafe officer and have a documented process/SOP with an escalation process for glaucoma and other high risk ophthalmic disease.

4. Introduction

Getting It Right First Time (GIRFT) is a national programme in England developed by the GIRFT national team under the chairmanship of Professor Tim Briggs. GIRFT has been designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The High Volume Low Complexity (HVLC) programme is a priority data-led transformation programme supporting the recovery of elective care services post COVID-19 pandemic. It aims to reduce the backlog of patients waiting for planned operations, improve clinical outcomes and access to services through standardised clinical pathways ([HVLC programme - Getting It Right First Time - GIRFT](#)).

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the chairmanship of Professor Tim Briggs, was approached by The Planned Care Improvement and Recovery Team (PCIR) which has commissioned GIRFT to undertake a review of the provision of ophthalmology services across Wales, concentrating on the most common operation, cataract surgery, and a high volume chronic outpatient condition, glaucoma. The project will look at all health boards, providing a report with recommendations to individual health boards and an overarching national report to help inform a future national ophthalmology strategy.

This report details the methodology, findings and recommendations arising from the data analysis, deep dive engagement and on-site evidence gathering on ophthalmology cataract and glaucoma services within this RNOH/GIRFT project.

RNOH/GIRFT have made a number of recommendations within this report. We believe that the implementation of these recommendations is essential if Wales is to deliver high quality and sustainable ophthalmology glaucoma and cataract services effectively and safely for patients in the short, medium, and long term.

5. Project Objectives

The ambition of the project is to help each health board to urgently improve cataract and glaucoma services to the maximum levels possible, to identify examples of innovative, high quality and efficient service delivery already in the system to spread learning, and to identify opportunities for improvement. The work across individual health boards can then be used to derive opportunities and address challenges at the regional and national level. The project looks at areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. It aims to assess whether a health board is using its existing resources and provisions effectively and is delivering the best outcomes for patients, and to understand where extra resources are needed to deliver safe, equitable, high quality care for patients.

GIRFT focusses on equity of access and excellent clinical outcomes for the population through standardisation of pathways and adoption of best practice. The project identified opportunities for improvement and transformation in cataract and glaucoma across the health boards by:

- Providing an overall picture of the specialty and **identifying outliers**
- Focusing on national and local organisation level to remove **unwarranted variation** in access to care and the outcomes of care
- Driving for '**top decile**' GIRFT performance of outcomes, productivity and equity of access
- **Standardising clinical pathways** agreed across all providers, developed by the multidisciplinary team and compliant with national guidance
- Informing potential **establishment of elective surgical hubs**
- **Agreeing principles** for working across clinical and operational groups e.g. theatre principles
- **Leaving a legacy of sustainable quality improvement** by working in partnership with your clinical, operational and analytical teams so that you are able to continue implementation and track progress at the end of our work with you.

6. Approach and Methodology

RNOH/GIRFT delivered a national webinar on 12th May 2023 which set out the background

and purpose of the ophthalmology project. We held a number of clinical and executive drop-in sessions from 21st May to 1st June to discuss details of the project and any logistical issues, hear informally about current service concerns and opportunities to be explored in more detail during the visits and to ensure engagement. We also met (virtually) with some regional ophthalmology service transformation leads, to understand their concerns and plans.

The data used in this review is drawn from RNOH/GIRFT questionnaires completed by each of the health boards in January 2023, providing data for the period Jan to Dec 2022, and we received more up to date information for some items during the meetings. The responses are compared with GIRFT standards and peer performance based on data in Model Health System ([NHS England - Model Hospital](#)) for England. The data from Model Health System relates to Quarter 2 of financial year 2022/23. This is the latest quarter for which data are available on Model Health System and approximately 60% of trusts in England submitted data for the RNOH/GIRFT questionnaires.

The site visits and deep dive engagements took place between 5th June and 5th July 2023 and were led by Mr. Jonathan Bhargava & Ms. Mel Hingorani (cataract), Ms. Lydia Chang and Mr. Wojciech Karwatowski (glaucoma). Each deep dive session was an opportunity for the health board to provide an overview of their ophthalmology services and current issues, and showcase good practice, and included a review of the RNOH/GIRFT data and a detailed discussion. We also discussed how new national guidance and high flow principles can help both elective recovery and long term transformation for sustainability for the health boards. All the meetings were well attended by a mixture of colleagues in ophthalmology roles (ophthalmologists, multidisciplinary (MDT) clinicians, theatre staff, senior managers and clinical leaders), all contributing to the excellent discussions. This allowed us to gain a good understanding of the issues facing each health board and their hospitals, to identify opportunities, and to suggest improvements in the short and longer term.

Following the visits, we have shared ophthalmology pathways and GIRFT, Royal College, UK Ophthalmology Alliance (UKOA) and other best practice and ophthalmic transformation documents and guidance as detailed in the Annex B.

7. Implementation Support Sessions

RNOH/GIRFT will provide the health boards with support to implement the recommendations made in their ophthalmology individual report. Each health board has been asked to set up an Ophthalmology Steering Group to include representation from the whole pathway MDT and executives across the health board, to ensure that the recommendations are converted to an action plan, and to allocate responsibilities to deliver these to the relevant people to share the workload. This group should have strong links with any regional ophthalmology steering group. We will convene monthly ophthalmology meetings with key ophthalmology leads from each health board and the Planned Care Team in the NHS Executive for six months, with a view to the first meeting commencing in September 2023. At these meetings, we will ask each health board to provide an update against their RNOH/GIRFT recommendations. GIRFT clinical leads will attend each meeting to provide ongoing advice.

8. Findings and Recommendations for NHS Wales and Welsh Government

8.1 Governance and Leadership

Across Wales, all health boards deliver ophthalmology, although Powys relies on sending many patients to English trusts and other Welsh health boards and delivers some care on site with English consultants visiting regularly. The [Pyott Report](#) highlighted many of the key issues across all ophthalmic services.

The findings from our work on glaucoma and cataract are summarised as follows. For all health boards, there are serious, significant and sight threatening delays to outpatient glaucoma care with thousands of patients waiting up to four years for glaucoma reviews, during which time some may be silently and permanently losing vision. This sight loss would be avoidable if seen and treated in time. Some health boards are significantly worse than others, but all carry risk which is not mitigated satisfactorily and there is little confidence that the current options for local improvement can be implemented at the speed and scale required for safety. Evidence based demand and capacity work to underpin realistic recovery plans is absent, with a lack of accurate and relevant data for outpatient care. Patients' individual clinical risk levels are not reliably being recorded to mitigate the risk of harm. Outpatient and pre-operative assessment facilities are inadequate in most health boards; too small for the size of the activity (busiest outpatient specialty), fragmented spaces, ill laid out for modern high flow and virtual diagnostics eye care, and often poorly maintained.

8.2 Staffing and MDTs

The efficiency and numbers on a list for LA cataracts are below what they ought to be; some are due to poor facilities but, in a good number of places, there are excellent day case cataract surgical facilities and plentiful staff numbers, which ought to be translating into delivery of higher volume lists. There are multiple opportunities to increase the surgical flow. We observed most consultant surgeons complete cataract surgery cases within 10 minutes and who, with the appropriate changes in process and multidisciplinary (MDT) staff skills, will be able to deliver better flow everywhere, and really high volume LA cataract lists in the well laid out units.

There are not enough ophthalmologist consultants to deal with capacity issues let alone develop and improve the services; particularly a lack of substantive subspecialist glaucoma consultants. There is a general shortage in the UK but Wales is really struggling to attract and retain ophthalmologists. There is significant inequity, with some health boards, such as Betsi Cadwaladr and Hywel Dda, finding it almost impossible to appoint, resulting in hugely delayed care for patients, and patients regularly being seen outside of a consultant-led team. Without consultant leadership time, even simple efficiency measures will not be able to be developed and implemented, and a vicious circle of decline occurs; it becomes impossible for units to support implementation of major change including rolling out use of electronic patient record (EPR) and developing systems for working with primary care. However, the substantive consultants whom we did meet were highly qualified, expert, patient centred, keen to improve their service and, in some cases, were already experienced during their training in higher volume cataract surgery. Their MDTs were also highly committed and ready to take on a wider scope of practice.

In terms of attracting and retaining consultants, it is important that there is significant thought as to what will actually attract them. A clear and visible commitment to regionalisation and resources for service improvement at national and local level will be key, but thought also needs to be given to where academic work can occur (e.g. working with the university optometry schools), service improvement time, management resource etc. Action is needed

to avoid the current situation where trainees accept training posts in Wales and then rapidly request a deanery transfer to England.

Change, even at local process level, needs significant resource to deliver. There are too few ophthalmologists and, for those in post, they have little or no funded time in their job plans for service improvement, professional development of the in-hospital MDT and primary care optometrists, managing relationships and pathways with internal and external stakeholders, developing and using digital expertise required for service transformation etc. Ophthalmic services have managers who are too junior, too stretched over multiple specialties, and change very frequently. Executives and health board leaders are not supporting and prioritising ophthalmology as they should, given the large numbers of patients in the service and the current unsafe delays.

Recommendation 1: Welsh Government with health boards to fund and appoint more consultants, develop a plan for and advertise the factors that will attract them e.g. Investment, good facilities, a clear commitment to improvement, regionalisation, educational and professional development opportunities, academic opportunities. NHS Wales to ensure that existing and new consultants have enough protected service improvement and clinical leadership time in their job plans to enact the required local recommendations – if necessary, through more funding.

Recommendation 2: Health Education Improvement Wales (HEIW) and ophthalmology leaders should continue to explore strategies aimed at improving recruitment and retention of trainees'.

Recommendation 3: NHS Wales to ensure that ophthalmology is properly prioritised at local organisational level so that chief executives and other key leaders in health boards provide the ophthalmic clinical and management teams with the support they need. NHS Wales to ensure health boards provide enough senior service management and project management support to implement the changes.

8.3 Organisation and Networks

Currently, there is still silo operating and unwarranted variation between and even within different health boards. There is little sharing of learning, mutual aid and regional pathways to utilise capacity flexibly and make the most of the existing facilities best suited for eye care. All of these issues are impacted by a lack of understanding and prioritisation of ophthalmology from executives and senior clinical leaders in the health boards.

Wales is already using expensive insourcing and outsourcing solutions and temporary facilities i.e. the Cardiff Vanguard unit. Local teams are very concerned about the potential increase in independent sector provision, given the issues well publicised by the [Royal College of Ophthalmologists](#) on the knock-on effects of lack of surgical training opportunities, drain of trained staff to the better paid independent sector and overall destabilisation of comprehensive ophthalmic services. Short term solutions risk becoming embedded for the longer term, unless there is a robust plan for what next. There needs to be a sustainable long term plan for meeting the current and future population-based demand for ophthalmology in Wales which, given the expense and sometimes negative impact of short term solutions, must be pursued urgently. A

realistic assessment needs to be made of which sites are never going to be suitable for modern safe ophthalmic care, with services moved away from these into more suitable sites. We fully support the establishment of a National Ophthalmology Strategy which is in development. The development of this strategy should take into account the various recommendations we have made about future ophthalmology models in Wales.

The local teams almost universally reported to us that they believe a regional, and in some cases (e.g. vitreoretinal services) national approach is needed to delivering care, and we agree. Only by working within regions, across traditional site and health board boundaries, with flexible use of the estate, capacity, workforce recruitment and deployment across the region, and using shared consistent processes, can the current difficulties be overcome. This will enable best use of the more suitable existing sites, moving ophthalmology in and moving other specialties out, and expanding the time the unit is used (6 day working, longer days). It will allow targeting of investment to fewer sites which can best deliver modern efficient care as centres with a critical mass of activity. In some cases, this may mean consideration of a purpose built “centre of excellence” but, in others, this may be possible to achieve with adaptation of current sites or use of the better existing sites. Different regions will need different solutions. In those with spread out geographies, there may be more reliance on ophthalmic diagnostic and treatment centres (ODTCs) and optometry or mobile sites; in others, greater centralisation into larger diagnostic hubs and clinics may be the best option. It is crucial that each region uses evidence-based data on population needs, access and travel challenges, to map out the capacity requirements for the current period and over the next 10 years.

Recommendation 4: NHS Wales to link up health boards in regional networks immediately, to move patients or staff as necessary to use current resources and capacity most efficiently and to equalise waiting times within and across health boards for cataract, glaucoma and other eye care.

Recommendation 5: NHS Wales to promote regional cross-health board ophthalmology services with appointments to the region not individual health boards, managed as a whole regional ophthalmic MDT. Health Boards making up regions need to ensure there are resourced regional ophthalmology transformation teams to develop and deliver the new regional services.

Recommendation 6: Welsh Government to rationalise and reconfigure all ophthalmic services to establish fewer suitable sites with a critical mass. Invest as required into existing or new facilities, to create surgical hubs, outpatients, ODTCs and larger high flow technician-led diagnostics and MDT virtual review sites, fit for modern ophthalmic care. Take into account the longer-term rising population demand for care, on site delivery of training for the MDT and primary care optometrists, geography and travel/access.

Wales is to be commended for its proactive approach to developing national standardised pathways for primary care optometry within the eye health examination Wales (EHEW) / Welsh Eye Care Service (WECS) system linked to the general ophthalmic service (GOS) contract, with about 95% take up (as it is not mandatory). This has already translated to more care being delivered in primary care and reducing avoidable referrals to hospital, although we did see how the performance of this for each health board is very dependent on actively maintaining the local relationships between the hospital and primary eye care teams. At the

time of writing the report, the consultation on GOS change has closed, and any residual issues have (we are informed) been addressed, with a plan to imminently roll out the new system.

This will make the current levels of EHEW (except low vision support) mandatory and introduce new levels 4 and 5 to allow inter-referrals between optometrists for management and for the hospital to discharge to or co-manage with primary care optometry for lower risk care such as some glaucoma. These changes are expected to come into force in October 2023 with a rapidly phased implementation to full roll out by Spring 2024. There is funding for development of optometrists for higher qualifications included, but there will be a significant bottleneck to this due to a lack of consultant numbers/time and physical clinic space in hospitals to support the professional development of the optometrists. Although there are frameworks for governance between the hospitals and optometrists, again this requires time for proactive work on relationships and local embedding to translate to better quality pathways in place for patients.

The plan to roll the OpenEyes EPR system nationally across hospital sites and primary care optometry has been discussed for years but is progressing very slowly and the project was transferred on 1st June 2023 from Cardiff and Vale University Health Board (CVUHB) to Digital Health and Care Wales (DHCW). The project is on pause for due diligence and project planning, with a view to agreeing the plan in September 2023 and then rapidly rolling out to conclude by March 2025. Even within the few Welsh hospitals that have OpenEyes locally implemented, there are many issues and glitches within existing modules which are not being sorted out locally and with very slow expansion of key subspecialty modules, and a reluctance of some clinicians to engage and use the system – sometimes because glitches are not addressed and the system is therefore poorly usable. Most hospitals do not have any ophthalmic EPR.

The lack of ophthalmic specific IT systems means that there is inadequate and poor quality data for: managing patients in and across sites; providing joined up care between optometry/community and hospital; audit and outcomes; performance management; demand and capacity work; identifying and managing risk; planning and improving services. It also reduces the ability to run efficient virtual diagnostics pathways. Moreover, some of the health boards conveyed the impression that they would not consider any sort of alternative digital option or workaround, whilst waiting for OpenEyes, leading to inaction in introducing standardised pathways and collecting data. If the health boards continue like this, whilst waiting for OpenEyes, it is highly likely that services will continue to remain in a state of limbo with ongoing data deficiency and a lack of pathway redesign. The delay in the implementation of OpenEyes thus appears to be engendering an element of ‘planning blight’ which it is important to rapidly overcome and avoid.

The DHCW project is aiming to address the OpenEyes electronic referral module (Open ERS) first, to reduce unnecessary referrals into hospital, followed by the in-hospital development. It is important to realise the huge challenges to overcome for success: addressing information governance, technical and process issues in large numbers of optometric practices using different IT systems and the need to avoid “double keying” through multiple application programming interfaces (APIs); many practices using paper records; limitations in optometric practice digital expertise; time to devote to implementation in busy optical practices with business pressures; health boards with stretched IT resources; few consultants who have no leadership time and limited digital experience; the need to engage clinicians and support them to use new systems in busy clinics; DHCW with stretched resources undertaking several major

concurrent projects and possibly an imbalance in which there is capital funding without enough revenue funding. Given the current date for roll out is March 2025, there will need to be consideration as to the realistic minimum viable product to achieve by then, for example limitation to the absolutely key subspecialties and in what order to roll these out.

Although imaging is networked within each site within most health boards, there is more variability in whether ODTs and multiple health board sites are networked together, limiting the ability for remote access of diagnostic data for virtual review pathways and for patient flow between sites. Some units are struggling with poor hardware to view multiple systems and, if EPR is to be introduced and work across Wales, consideration must be given to suitable hardware and the need for dual screen PCs.

Recommendation 7: DHCW / Welsh Government to urgently accelerate the development and implementation of the OpenEyes national ophthalmic EPR and electronic referral system, within all hospital eye services, in ODTs and in primary care optometry, and in doing so:

- **Ensure health boards have support and resource to implement not only technically, but also in terms of change management, engagement with and support for clinicians using the systems.**
- **Ensure that DHCW has enough technical and non-technical manpower and revenue as well as capital resource.**
- **Prioritise the key subspecialties and develop in the same order in each health board so that mutual learning can occur. Ensure the “big 4” subspecialties are prioritised i.e. cataract, glaucoma, medical retina and urgent/emergency care. Consider starting with cataract which is the simplest to implement and has instant benefits for clinicians.**
- **Include in the OpenEyes funding suitably good grade and high spec dual screen PC's for more effective and rapid clinical decision making by the MDT.**

There are enormous opportunities to develop the MDT to do more within the hospitals and within primary care optometry, which are described throughout the health board reports and in section 6 of this report. There is a particular opportunity to recruit more hospital optometrists – there is a paucity of these compared with other parts of the UK and they are able to deliver a wide scope of care at a senior level with in-house training and higher qualifications. Every health board is currently battling to solve this locally, compounded by local uncertainty on what is “allowed” or resistance to change within senior MDT health board leadership, with no access to standardised development and competency resources. Only through all the MDT working at the top of their license will there be enough professionals within consultant-led teams to deliver the ever-increasing workload, and this is most efficiently solved once at national level.

Recommendation 8: Health Education Improvement Wales (HEIW) to work with NHS Wales to lead a task and finish group to review opportunities to strengthen multi-professional working across the eye care pathway identify appropriate education and training pathways.

We are aware of the numerous reports, plans, pathways and calls to action published over the last 15 or so years to transform Welsh ophthalmology which have not translated into delivery of change. It is now essential that the recommendations in this report are immediately taken forward and real action occurs to improve care for patients, eliminate the delays causing

permanent harm from glaucoma and failure to access sight restoring cataract surgery, and to put in place a structure and ways of working across Wales to deliver them. Time is of the essence; each month, more patients are avoidably visually impaired or avoidably losing vision permanently. Delay will also mean further expensive short term solutions and the risk of permanently embedding independent sector rather than NHS provision with diversion of funds from NHS providers and potential destabilisation of comprehensive NHS services.

We are pleased to see that the National Planned Care Team have recently established a Clinical Implementation Network (CIN) across Wales for Ophthalmology and we recognise that the CIN will have a key role in bringing health boards together to share learning. We support the establishment of the Ophthalmology Clinical Implementation Network (CIN) which will join up regional teams for mutual learning and standardisation of processes and support the changes required to be undertaken at national level. The CIN will also play a key role in ensuring delivery of our National GIRFT recommendations and also in ensuring that health boards implement their own recommendations.

Recommendation 9: NHS Wales to ensure that ophthalmology is prioritised at national level and to support and accelerate the ongoing development of the national ophthalmology strategy with rapid implementation of the changes agreed in this.

Recommendation 10: NHS wales should ensure that the CIN works with health boards to develop a set of key metrics for ophthalmology which should then be rolled out to health boards to measure and report against.

Finally, changes at the local health board and regional level should not be delayed waiting for the “big national solutions” i.e. OpenEyes, new build centres of excellence and the new primary care optometry contract. These will inevitably take time to come to fruition and deliver large scale change. It is important that local quick win changes are put into action, as each month matters for delayed glaucoma patients or functionally blind cataract patients awaiting an operation. For this reason, the rest of our recommendations are for NHS Wales to provide support and monitor implementation of the local health board recommendations.

9. Findings and Recommendations Related to Health Board Level Themes

The following recommendations were made to all or most health boards and should be supported and monitored by NHS Wales

9.1 Cross Cutting Findings and Recommendations

In many health boards there is a lack of a governance framework, clinical leadership and stable service management resource to drive change. There is a significant deficit in consultant numbers for the population served, such that they are fire-fighting and struggling to deliver clinical care, leaving no time for leadership and service development. This is compounded by a lack of prioritisation of, and support for, ophthalmology from health board leaders, despite the large patient numbers.

Recommendation 11: NHS Wales to support and encourage all health boards to set up an Ophthalmology Steering Group to include representation from the whole pathway multidisciplinary team and executives across the health board, with resourced clinical

leadership and project management time, to ensure that these recommendations are implemented and embedded, along with any other improvements the health board identify themselves. This group should have strong links with any regional ophthalmology steering group. We recommend that these are established without delay.

In most health boards, the line management of the whole ophthalmology team is not unified and not well enough resourced. Some of the team are managed via surgery, some by outpatients and some by ophthalmology. This leads to a less stable and fragmented team, prevents ophthalmology getting appropriate support and means that its people and resources are adversely affected by the demands or crises of other surgical specialties. Ophthalmology service managers are very stretched across multiple services and change frequently, so that improvement cannot be pursued effectively. It is useful if theatre and day case staff can work in outpatients and pre-op assessment and vice versa, to understand how each aspect impacts the other and for a cohesive team.

Recommendation 12: NHS Wales to support and encourage all health boards to review the ophthalmology line management structure and explore whether an MDT cataract or whole ophthalmology team across all areas (outpatient, day case, theatres, pre-op, imaging) dedicated to ophthalmology will work better. Consider whether to use staff more flexibly across these different areas e.g. using clinical nurse or optometry specialists in theatre or day care. Provide dedicated, stable and senior enough ophthalmology service managers.

9.2 Cataract Findings and Recommendations

9.2.1 Primary Care Integration for Cataract

Wales has established and continues to build up a consistent national approach to working with primary care optometry, something England has really struggled to do. Optometrists across Wales are able use the Level 2 EHEW/WECS to refine referrals; in most areas, this is working well to keep patients who do not want nor need cataract surgery out of hospital clinics. The optometrists also can undertake the routine post-operative checks in most patients.

The performance of the current optometry pathways is mostly excellent, but not everywhere, and shows that each hospital must put work into its relationship and communication with local optometrists for these contracts to translate into a high performing pathway. Data returned from optometry needs to have a way of getting into the records and then being audited to ensure outcomes are available, until such time as the new national OpenEyes record launches.

To ensure the planned GOS contract change can deliver its future potential, there will need to be well developed clinical governance and communication frameworks across primary, community and secondary eye care, methods to ensure consistency and quality of imaging and assessment standards, and the roll out of OpenEyes will be fundamental to this.

Recommendation 13: NHS Wales to support and encourage all health boards to ensure they work closely with local primary care optometrists providing feedback and communication, and create ways to ensure high conversion rates and good post-operative data return which is fed into records and audited.

9.2.2 Pre-operative Clinics and Assessments

Assessments for patients prior to the day of cataract surgery, whether general anaesthetic (GA) or local anaesthetic (LA), should be completed in a one visit (one stop) assessment rather than multiple attendances, to complete the eye assessment, the anesthetic/general health assessment, the consenting, biometry and choice of intraocular lens (IOL). This frees up significant clinic capacity for higher risk patients and reduces unnecessary long-distance travel for patients, particularly important if surgical capacity is being shared across a region. In addition, the pre-op needs to be very robust and well documented, done within 3 months of the date of surgery i.e. not too far in advance, performed by the MDT working to consistent standards and overseen by a consultant surgeon. It is crucial this is done well and is one of the most important factors in achieving on the day of surgery efficiency and high volume lists. High quality assessments, with clinical findings which are trusted by the surgeon, where all the checks are completed before the day of surgery, avoid any “surprises on the day” and eliminate the need for consultants to undertake lengthy pre-op ward rounds and consent the patient on the day of surgery.

Currently, although most units are trying to undertake one stop pre-ops, there are multiple issues across the health boards with capacity and the quality of the assessments. As high volume surgery gathers pace, this will become an acute bottleneck.

There are issues with:

- Space
- Equipment (modern IOLMaster 700s not 500s are needed)
- Enough MDT staffing and staff productivity (number of patients seen per session was highly variable)
- Using staff to the top of their license (health care support workers [HCSWs] and technicians should undertake the lower level tasks including biometry and simple health questions and general health observations [“obs”] and blood tests, freeing up the nurse and optometrist practitioners to be clinical decision makers)
- Appropriate protocols
- Suitable paperwork.

With appropriate training and competency signoff, nurse, optometrist and orthoptist practitioners can and should undertake most of the assessments: examination on the slit lamp of the front of the eye, the dilated assessment of the fundus (back of the eye), counsel and consent the patient, undertake the health assessment and, in some cases, choose the intraocular lens (IOL). The surgeon can then “pop in” and check the findings briefly and speak to the patient, so that there is surgeon oversight across large numbers of patients in any one session. Patients for sedation or GA can have their notes reviewed by an anesthetist later. There are difficulties with enough numbers of these MDT practitioners, training time, and acceptance of this practice, including, often, by senior non-ophthalmic nurse leaders who can rule that they are “not allowed” to do this. In one health board, nurses had been successfully consenting for cataract, and were told they had to stop.

Conversion rates can be improved (i.e. reduce those coming unnecessarily who do not want surgery), and the face to face session can be very short, if the practitioners undertake phone

calls after receipt of the referral to ensure patients want surgery and to pre-populate the records and undertake some consent counselling.

Recommendation 14: NHS Wales to support and encourage all health boards to improve pre-operative assessments for cataract surgery:

- Do all cataract pre-ops as a one stop, even GAs and complex cases, especially for patients living far away. Adopt a national ‘normal practice’ pathway for one-stop clinics to address varying practice.
- The whole pre-op attendance needs to be reviewed and the team given the resources they need (e.g. space, enough trained MDT staff, a consultant with enough slots to see all the patients briefly, with everyone working to the top of their license) to ensure an efficient and robust one-stop pre-op assessment is done within a short timescale (no more than 3 months) to surgery date.
- Use hospital optometrists and nurses to undertake phone calls to screen out patients who don’t need surgery and to counsel and pre-populate pre-op assessment documents for those who do go ahead. Add e-consenting signatures or even send the consent form by post.
- Expand the staffing and the remit of the MDT in pre-op assessments, with technicians and HCSWs doing more of the routine workup and biometry, and practitioners including nurses, orthoptists and optometrists able to undertake the slit lamp and fundal checks and consent; obtain IOLMaster 700s to support a wider range of staff to undertake biometry.

9.2.3 ISBCS (Immediate Simultaneous Bilateral Cataract Surgery).

Although many health boards reported ISBCS is offered, in fact this is rare, partly because most cases are done under block anaesthetic (which reduces the vision) rather than topical and because some cases are complex and not suitable; but it is a reasonable option for many straightforward cases. It will require much more use of topical anaesthesia and willingness from more of the consultant body. Some units had basic logistical issues preventing them offering this when they wished to e.g. overly slow instrument set turnaround times from HSDU (hospital sterilisation and decontamination unit), no storage space for consumables from different batches for each eye. Offering ISBCS to all appropriate and suitable patients proactively and routinely is a strong GIRFT and RCOphth recommendation to improve efficiency and get more cases done on the day and most patients will be very keen to have this done. If mutual support for capacity or a regional surgical hub is established, it will create a much better patient experience. This is becoming routine in England and is already being done in Powys.

Recommendation 15: NHS Wales to support and encourage all health boards to offer ISBCS to all suitable patients.

9.2.4 Risk

Many units do not use a consistent risk rating as recommended by the College and GIRFT to identify higher risk patients and direct patients to the right list and book the right amount of time on the list. Doing this can help benchmark the productivity of different units or surgeons

who may or may not have differing levels of patient complexity to account for variations in numbers. It allows rapid, specific identification of patients suitable for HVLC lists and these patients can be called in at short notice in the event of any cancellations. It's even more important if booking patients into multiple different surgical sites.

Recommendation 16: NHS Wales to support and encourage all health boards to introduce standardised risk ratings in line with College guidance for cataract surgery recorded on waiting list forms and to identify suitable patients for HVLC lists.

9.2.5 Co-morbidities

None of the health boards are managing co-morbidities for LA cataract surgery according to GIRFT and RCOphth guidance, and some of the surgeons and many of the anaesthetists are not even aware of it. There are no local written protocols for co-morbidity management for cataract surgery. The way in which co-morbidities are being managed in a non-evidence-based way is limiting the time available for more cases on a LA cataract list. For LA cataract surgery, all assessments on co-morbidities must be completed and agreed to be within safe limits before the day of surgery. Issues identified are addressed and, if necessary, surgery deferred, until it is safe to proceed. This will avoid the significant nursing time spent on routine observations ("obs") and extra blood tests. Following the national guidance would save valuable time during the pre-op assessment and on the day of surgery and reduce the variable and sometimes high cancellation rates on the day.

Recommendation 17: NHS Wales to support and encourage all health boards to create a protocol on managing co-morbidities for LA cataract surgery based on GIRFT/RCOphth guidance, simplify relevant pre-op- and on the day of surgery documentation in line with this, and train staff to implement.

9.2.6 On the day of surgery

Numbers of Cases

Efficiency is much higher when cataracts are done on dedicated lists but some units are still doing mixed lists. Most units are doing 5-6 cases per LA cataract list but there is variation between units and surgeons. No units have established routine HVLC lists. This is less than currently in England (median of 7 pre-Covid), and less than the 8 to 10 in best performing English units. The GIRFT / RCOphth standard is that there should be at least 1 patient per 30 minutes of theatre time in a LA cataract list, giving 8 in a 4-hour session, although this may be less with very junior trainees and with higher complexity patients. Given that many of the Welsh units have well laid out cataract theatre suites, and have committed and high performing cataract surgeons, they should be achieving a much greater throughput than currently. A very small number of surgeons have performed high flow lists. E.g. the lead surgeon at Aneurin Bevan University Health Board (ABUHB) personally undertook pilot high flow lists during a "cataract month". During insourcing, some local surgeons performed 10 LA cataract cases per list; although there are financial incentives which contribute to this, it shows it is possible. There is an opportunity here to incentivise both surgeons and the MDT theatre teams within the NHS structure if terms and conditions could be changed to reflect productivity. However, we would argue that the many long waiting and functionally blind cataract patients across Wales, whose sight could be returned with a procedure which takes 10 minutes of operating time, should be incentive enough.

Many lists are training lists, which can limit the ability to undertake HVLC lists if there are junior trainees, and there are routinely mixed complexity lists which can slow things down. Separating out the training/complex and doing these in a slower list allows the delivery of a really high volume lower complexity list of 9 or 10 cases. There is a common misconception that high flow and efficient approaches are only applicable to lower complexity cases, which is incorrect. The College and GIRFT guidance has moved from the term HVLC cataract lists to *high flow for all complexity* cataract lists, although we recognise that there may not be 10 cases on a higher complexity list. However, that high complexity list will still be able to deliver more cases than previously.

Recommendation 18: NHS Wales to support and encourage all health boards to increase the number of patients on a LA cataract list:

- **Do LA cataracts on cataract only lists. Use high flow processes for patients of any complexity.**
- **Start to undertake HVLC lists with lower complexity patients or build on existing pilots:**
 - **Consider removing trainees for some HVLC lists at the beginning, to “prove the principle”, then roll out the learning and incorporate trainees, to ensure they learn to deliver within HVLC lists (any removal of trainees needs to be considered in conjunction with HEIW).**
 - **Organise HVLC list pilots alongside a more complex list, if two theatres are available, to allow anaesthetic support for unstable patients and/or take over the patient if any unexpected complications occur and to test the waters.**
- **Agree more cases per list and do not finish early routinely or take a leisurely approach. Patients are waiting a long time for sight restoring surgery and this must drive everyone to operate efficiently and optimise surgical time. If high volume surgery with high numbers are achieved, early finish should be acceptable as a bonus to teams who achieve this.**

Starting on Time and “Pre-op Ward Rounds “

In most units, patients arrive with little or no staggering and have an unacceptably long journey time, although we found a lot of variation in this between units and between surgeons within units.

The lack of staggering is to allow the surgeon to not only mark the eye but also to do a “pre-op ward round” to recheck the history, examine the patients on the slit lamp and to take consent, as consent is not being taken before the day in many cases, and the pre-op assessments are not fully trusted, may not have happened fully (e.g. second eyes), or have happened a long time ago. In addition, nurses may be instilling multiple sets of drops (as some surgeons do not want to use the pupil dilating pellets), undertaking observations and doing blood tests for diabetes and warfarin. In some units, we saw temperature and Covid tests being done which we were told are no longer required. This is inefficient and delays the start of the list. In those health boards with a poor day-case admission area, this means that patients have a lack of dignity and privacy as they sit crowded together for hours, undergoing multiple unnecessary interventions. This was worsened in some health boards by surgeons having a job plan contract which precluded them from starting work early enough to get the list started on time.

There are multiple opportunities. Trained nurses can consent or confirm consent, mark the eye; patients can do self-dilating i.e. insert their own eye drops at home before leaving for the hospital or, where they need to be dilated in hospital, can receive one dilating pellet on arrival; doctors do not need to examine patients and take consent on the day, and nurses do not need to do on the day obs, as long as consent is done before the day, there is a robust pre-op one stop and the GIRFT co-morbidity guidance is followed. Then the surgeon only needs to greet the patients in the anaesthetic room by popping out between cases. The surgeon can check the notes or ideally have checked the notes the day before or before the start of the list. All this would mean a much shorter and more dignified patient journey on the day, an early start to the list, and the surgeon freed up to do more cases.

Recommendation 19: NHS Wales to support and encourage all health boards to improve on the day of LA cataract surgery experience and efficiency:

- **MDT trained and empowered to mark the eye, check or take consent etc.**
- **Eliminate surgeon pre-op ward rounds for LA cataract lists. Consultants only check notes and greet and reassure the patient, ideally in the anaesthetic room.**
- **Ensure the admission area to be suitable, avoid queuing patients in the corridor and eliminate any unnecessary Covid tests.**
- **List order and details MUST be agreed before the day and have a “golden patient” listed first.**
- **Use pellets for pupil dilating (unless the patient has performed self-dilatation) and not drops.**
- **Consultant job plans and staff rostering to be arranged to allow lists to start on time and a move from 3.75 hour lists to longer LA cataract lists where possible.**

Theatre Utilisation and Turnaround Time including Positioning and Trolleys

The data pack reported very variable theatre utilisation times from 58% to 86%, and inter-case downtimes of 2 to 25 minutes but, even in those with better numbers, our observations showed that there is significantly more operating time available than the figures suggest.

In all health boards, the operation itself was efficiently performed, usually within about 10 minutes for consultants and 10-20 minutes for trainees. But there was a lot of downtime, not only late starts but also 10-12 minutes between cases. In most places, the teamwork was good with teams clearly capable of higher performance and more cases.

Factors for slow turnaround included:

- Anaesthetic blocks delaying rather than speeding entry of next patient into theatre
- Patients climbing on and off the operating trolley/couch in the operating theatre, rather than the anaesthetic room
- Slow, dated theatre IT systems
- A general lack of team pushing for higher throughput
- Failure, or lack of suitable space, to prepare instrument trolleys for the next patient early enough
- Doing the “pre-op ward round” in the anaesthetic room
- No routine early sending for the next case by the MDT
- In some cases, a day case area much too far away from the theatre
- Failure to have a pre-populated or template operation note

- Post-op instrument counts not being done early or efficiently enough
- Inadequate use of the MDT (see below).

Recommendation 20: NHS Wales to support and encourage all health boards to improve turnaround times in LA cataract lists:

- **A member of the MDT should send for the next patient routinely at an agreed point in the current case, without having to be told do so by the surgeon.**
- **Use the anaesthetic room for the LA to be given and patient positioned on the trolley. Wheel the patient in and out of the operating room on the trolley or couch.**
- **Undertake the instrument count in the last few minutes of the case.**
- **There should be a standard cataract operation note template and the note should be pre-populated by the MDT.**

9.2.7 Cataract Surgical Estate and Facilities

We were pleased to see that there are many truly wonderful facilities in which the day-case and theatre suites are large, clean, co-located and perfect for high flow ophthalmic surgery. These include:

- Princess of Wales Hospital, Bridgend in Cwm Taf Morgannwg University Health Board (CTMUHB)
- Llandrindod Wells Community Hospital and Brecon War Memorial Hospital in Powys Hospital Teaching Board (PTHB)
- University Hospital Wales in CVUHB (although with one minor issue and the temporary nature of the facility)
- Singleton Hospital day surgery unit in Swansea Bay University Health Board (SBUHB)
- Royal Gwent Hospital in ABUHB; (there are some issues these are about maintenance and space use which can be solved).
- Ysbyty Gwynedd Hospital in Betsi Cadwaladr University Health Board (BCUHB)

These are not used to their best potential. There are other specialities in there, especially since Covid, which do not need a high flow unit. There are sessions lying fallow. There are late starts, early finishes and short (3.75 hours) lists. Weekends are not used, nor 3 session days. This is a real waste. Freeing up and using space in these units could allow more cases, including to support other more challenged health boards.

In Cardiff, there is real local concern about the cost of the temporary facility and the need to develop a longer term solution. The old Theatre 8 is completely unsuitable for high volume surgery and the Vanguard unit is supporting capacity across the region. There needs to be a proper regional solution.

There are real issues with the surgical eye facilities in:

- Royal Glamorgan Hospital (RGH) in CTMUHB
- Abergele Hospital in BCUHB
- Glangwili Hospital in Hywel Dda University Health Board (H DUHB).

For example, the Royal Glamorgan arrangements are unacceptable, completely unsuitable for efficient high volume cataract surgery and for the experience and dignity of elderly sight-

impaired patients. Every step in the pathway is far away geographically from the next step. Lifts do not work. The day care area is in a locked, dark, cramped and busy old maternity ward with a slit lamp at the other side of the ward difficult and unsafe for elderly sight impaired patients to be walking back and forth in. It is physically impossible to transport the patients to the eye theatre during the 10 minutes it takes for the previous case.

In Abergele Hospital, the day-case unit was a significant distance from the operating theatre and often staff were not available to bring the patients to the theatre in good time, or at all, because of staff shortages. An appropriate space that is currently being used by administrative staff which is much closer to theatre has already been identified as a potential day-case unit but not set up for this so far.

In Glangwili hospital, again the distance to the operating theatre from the day-case unit prevents swift turnaround times. The day-case unit and theatres are on different floors of the building. As everywhere, space is limited but an urgent reconfiguration is essential to improve the patient pathway.

Although the Cardiff Vanguard offers capacity to ABUHB and CTMUHB patients, otherwise there is little regional or cross-border use of the many very good facilities to support those units with challenges.

Recommendation 21: NHS Wales to support and encourage all health boards and regions to optimise use of current surgical facilities for LA cataract:

- **In the most suitable eye theatres, use the fallow sessions and move other specialties out, to run more eye lists. Consider long days or 3 session days, 6 day working week and avoid short (3.75 hour) lists to optimise use of the facilities. Start lists earlier and ensure job plans and rosters accommodate all these changes.**
- **Equalise waits across sites, and shift patients to where the capacity is within the health board or region.**
- **Urgently scope changing the facilities provided in Royal Glamorgan Hospital, Abergele and Glangwili, to provide a safer day case area and theatre much nearer to each other. If improvements not possible, care should be moved to other units.**
- **Sort out any basic logistics of the stock checks and replenishment, HSDU, storage etc. as soon as possible.**

9.2.8 Cataract Workforce

Some of the units, such as Swansea and Bridgend, are to be commended on their long term commitment to and success in extending the roles of the MDT.

A dedicated core ophthalmic theatre and day care team is preferable for efficient performance and to ensure the correct extended skill set for every cataract list. There are no nurses or other non-medical professionals routinely doing iodine (antiseptic) prep of skin, applying the drape, inserting the speculum, positioning the microscope ready for the surgeon, or pre-populating the operation note. MDT staff can be trained to do this, so the surgeon concentrates on operating.

Very high performing units often use extra staff to support higher throughput lists and some of the high number lists during insourcing were made possible by having an extra HCSW.

Despite there now being a national AGORED course to support development of cataract scrub practitioners, in which HCSWs act as “scrub nurses”, only one unit (Swansea) had such a practitioner, and there was a disproportionate degree of effort, time and personal determination required; it took years. The development of such staff is a clear and significant opportunity to develop a stable extended role cataract theatre MDT who cannot be pulled away to other specialties.

Overall, there is a big opportunity to improve the pre-op, admission and theatre flow and patient experience by expanding the number and the roles of the ODPs, nurses/optometrists/orthoptists and health care support workers (HCSWs) and technicians.

See recommendations 14 and 19 for staffing use in pre-op assessment and day case areas.

Recommendation 22: NHS Wales to support and encourage all health boards to improve the utilisation of the non-medical MDT on the day of surgery:

- Undertake a whole MDT workforce review, pushing everyone to the top of their license and assessing numbers and training requirements for cataract and HVLC
- MDT staff trained and empowered to routinely prep the skin with iodine, apply the drape, insert speculum, position microscope for surgeon, draft the operation note, print the op note/letter/discharge medication.
- Where cost effective, use more nurses or other MDT staff to accompany the patient around the whole on the day journey to achieve higher list numbers.
- Accelerate the training and improve career ladder of scrub practitioners who are HCSW's including through the national workforce project (recommendation 8).
- Use the Modelling software available RCOphth cataract workforce calculator ([RCOphth cataract workforce calculator tool | The Royal College of Ophthalmologists.](#))

Anaesthetists

In very high volume cataract units, most straightforward cases are performed using topical (drops and intra-cameral i.e. inside the eye local anaesthetic drug) anaesthesia. Subtenons block procedures, which take longer, requires specific skills and training, and have some small risks but provide a stronger control of the sensation in the eye and reduce eye movement, are then reserved for some higher risk or anxious cases and for some junior trainees. Some Welsh consultants do topical anaesthesia but most use blocks routinely. At Powys, the consultants come from England and use topical, but Hywel Dda consultants also use topical anaesthetic.

Currently, nearly all the LA cataract lists except at Powys and Hywel Dda have an anaesthetist. There are three main arguments for doing this: to speed up the list by ensuring the patient is anaesthetised and ready to go as soon as the last case is finished; that in Wales there are more patients with unmanaged co-morbidities, more difficult/complex cataract operations and the patients are potentially less able to be co-operative enough for topical; patients may become unwell or need resuscitation. In most English units there is no anaesthetist routinely present in any LA cataract lists, including standalone units, although there does need to be a member of staff intermediate life support (ILS) trained, a good resuscitation pathway and a member of staff dedicated to monitoring the patient.

The local anaesthesia was not efficient in most units. The anaesthetists were using unnecessary excessive paperwork and were often not familiar with the most up to date national guidance. Often giving the blocks was actually delaying patients entering theatre and slowing things down. This rather negates the efficiency advantages of having an anaesthetist at all. If the anaesthetist is not delivering the blocks to enhance flow and sometimes delaying progress, it seems an expensive and non-efficient situation.

In addition, we observed many operations throughout Wales during our visits and did not see a particularly highly complex set of patients and eyes precluding more topical anaesthesia, although complexity (i.e. cataract density) is higher than usual everywhere due to long waits. We observed very co-operative patients. Patients becoming severely unwell or requiring resuscitation is a highly unusual occurrence in LA cataract lists. We do not think Welsh patients are so different from English, and it was clear from the practice in Powys and Hywel Dda that topical anaesthesia and local anaesthetist cataract lists without an anaesthetist works well and is safe for Welsh patients.

Recommendation 23: NHS Wales to support and encourage all health boards to:

- **Move to topical anaesthesia as a default for all suitable cases.**
- **For patients who need blocks, train other staff e.g. nurses, ODP, physician assistant, to administer blocks.**
- **If using a subtenons block, the block must ALWAYS be done early enough and whilst the previous case is in being operated on, so that the patient is ready to come into the operating room with no delay.**
- **Cease the routine use of the anaesthetist in LA cataract lists and agree a pathway with other anaesthetists or ambulance service to cover the occasional unwell patient.**

Surgical Trainees

Training of surgeons is a regular part of most health board cataract lists. Most have access to a simulation device. Trainees are not involved in high flow lists as they are not really up and running. We note that there is a general tendency to reduce numbers for trainees and although to some extent this is required, through modular training and using more experienced trainees well, high numbers can still be achieved (see [College guidance on training in high flow lists](#)). It is crucial that surgeons in training learn how to work and operate in high flow lists throughout their training, so that, as consultants of the future, they can deliver the higher flow surgical lists that will need to be routine across the UK. In addition, we note that the presence of trainees is often cited as a reason that HVLC cannot be done. However, we note that in units such as Hywel Dda and Powys, there are no trainees on the lists yet the numbers are not higher.

9.2.9 Cataract Records and IT Systems

Most units are still using primarily paper records. There was enormous variation in the paperwork used for the LA cataract surgical pathway. Some units had developed LA cataract booklets which were reasonably lean but then often there are a number of other papers which are separate, and there was always room for improvement - to make leaner and to support processes related to our recommendations.

In some units there was a significant issue in the LA cataract paperwork, in which teams were forced to use generic, duplicative, unnecessarily lengthy paperwork for pre-op assessment, admission and theatre, which is meant for other specialty major surgery; for example, in HDUHB, BCUHB and Royal Glamorgan Hospital. As well as placing a burden on staff, it slows the whole process and creates patient safety risks; the key information might well be missed or lost in the volume of paper and irrelevant data, causing a never event (e.g. wrong IOL insertion or wrong side operation).

In units using the TOMS theatre IT software, it was a slow, outdated system, pulling staff away from the patient to the computer terminals and slowing things down. There was often paper form duplication.

Recommendation 24: NHS Wales to encourage and support all health boards to improve cataract record systems:

- **Review the documentation for LA cataract surgery against the GIRFT guidance and example booklet, remove all unnecessary data collection and incorporate all relevant documents into one lean booklet which supports the new processes. This is urgent in areas where there is excessive and generic paperwork.**
- **Review the use of TOMS and consider an improved system across these health boards. Whilst TOMS is in use, use a tablet to enter the data so the system does not pull staff away from patients.**

9.2.10 Audit and Clinical Governance

Only Cardiff and Royal Glamorgan (CTMUHB) who have an EPR, are able to submit data to the NOD national cataract audit. Some do regular internal audits, for both the whole unit and for individual surgeons but some are not getting the post-operative information back from optometrists or not entering it into the records and then auditing. Where information was available there were low (good) posterior capsular rupture complication rate and visual acuity loss rate. It is crucial to ensure, even in the absence of an EPR, that post-operative data is returned from primary care optometry, entered into the records and used to quality assure on cataract surgery outcomes for all units and all surgeons. This will become even more important as practice changes e.g. to topical anaesthesia and ISBCS, for reassurance that this has not had any negative impact.

Due to the fragmented line management structure and multiple units with silo working in some areas, in most health boards there are no regular MDT clinical governance meetings which join up the whole ophthalmology team including theatre, outpatient and pre-operative teams. Although many health boards do have audit half day meetings up to every month, the various parts of the eye team are meeting separately. This means the team do not join together to discuss and solve issues across the whole pathway and are not communicating effectively.

There is no regular observational audit of theatre flow in the health boards, which rely on the data entry by theatre staff into the theatre system to assess theatre pathway timings; we know this is highly unreliable. Simply getting a consultant, a nurse and a manager to go to someone's list and observe or record timings, as we did, would be very powerful and helpful to improve flow.

Recommendation 25: NHS Wales to support and encourage all health boards to improve clinical governance:

- Ensure regular internal cataract audits are done looking at PCR and visual loss for the whole unit / individual surgeons and support with audit and admin staff as necessary.
- Use the audit sessions to join up the WHOLE cataract / ophthalmology pathway team including theatre staff to review processes and performance and drive improvement.
- Undertake regular observational audits to measure and monitor the flow in cataract lists.

9.2.11 Acute Surgical Events.

In most health boards there were agreed processes to report complications and post-operative infections back from optometrists, although it was less clear that there were such processes between different units established where there were any mutual aid or regional surgery pathways. Health boards were able to describe a clear pathway for the acutely unwell patient in theatre. Cataract surgery patients with serious complications such as a dropped nucleus can get access to vitreoretinal surgeons (VR) but this often involved travelling. Although many units relied on Cardiff, which for some is quite a long distance, there was concern that Cardiff could not cope with accommodating all these patients who need access within 24 hours, and patients were having to be sent to Bristol, Oxford etc. Although VR is not the primary focus of this report, we wish to reiterate the concerns which have been expressed for some time including in the Pyott report that Wales is not offering a suitable service and that a national VR service needs to be established.

Recommendation 26: NHS Wales to work with health boards to establish a national vitreoretinal service.

9.2.12 Patient Focus

Patient surgical journey time

In many units, patient arrival times for LA cataract surgery are not staggered so patients are having very long journey times on the day of surgery. This is a poor patient experience and many English high volume units, and some of the Welsh units, allow staggered arrivals. Staggering will be possible as long as the pre-op ward round can be abolished and the other pre-op assessment and on-the-day recommendations are done.

We noted that most units use standard prepacked post-op drops which allows them to discharge the patients rapidly after surgery and this should be done in all units.

In most health boards, suitable patients are not self-dilating with drops at home (consultants told us they feel it will not work) and patients receive a pupil dilating pellet or sometimes drops (often due to surgeon individual preference); pellets are more efficient and free up nursing time. We have seen self-dilatation work even in very deprived and ethnically diverse areas of London and in some Welsh units e.g. Bridgend; it allows the patient to come later and frees up nursing time.

Recommendation 27: NHS Wales to support and encourage all health boards to reduce patient journey times:

- Establish staggered patient arrival times and ensure patients have pre-packaged

standardised post-operative drops which can be dispensed in the day care area.

- **Where not already doing this, undertake a pilot of patient self-dilating and, once the process is established, roll out to all suitable patients. Where patients need dilating at the hospital, use a pellet not drops.**

Consent and patient information

We had a significant concern about the consenting being done on the day routinely in many health boards. This is against GMC guidance and simply not appropriate to be accepted as routine; it is poor practice and not good for patients. We saw many consent forms which were not suitable for visually impaired elderly patients, being crowded with a lot of information and of very small font. We saw many units where there is no cataract specific consent form, so the surgeons spend time during the list repeatedly filling in all the standard risks and benefits and the patient cannot see it because their pupils are dilated and it's in tiny font.

Recommendation 28: NHS Wales to support and encourage all health boards to improve patient consenting:

- **Consent must be taken before the day of surgery. Consider supporting the primary care optometrists to do more and share the consent form. Consider posting the consent form out to patients in advice, nurses and optometrists in clinic to be trained to consent.**
- **Use an appropriate cataract specific consent form similar to the RCOphth consent form, which is approved by the major patient charities as accessible.**
- **Consent patients for both eyes at the first eye pre-operative visit. Consent by phone for second eye if already on list and post consent form out to read +/- sign at home or use e-signature.**

Equity

In some units, GA and complex cataract patients are being unfairly delayed compared with LA cataract cases. It is important that plans for reducing the backlog also consider such patients and utilise regional capacity to support these patients access to timely surgery.

We support the so-called Friends and Family list concept, with dedicated sessions to do more complex patients and also patients with language difficulties, limited capacity etc. who can be accompanied by friends and relatives, and appropriately reduced list numbers and extra staff resources can be put on to support these lists. We can put health boards in touch with Stoke Mandeville to describe how to do this if they wish.

Recommendation 29: NHS Wales to support and encourage all health boards to reinstate GA cataract surgery in all suitable facilities and use capacity across and between health boards to equalise waiting times. Consider using a Friends and Family list approach for patients with particularly complex needs.

9.3 Glaucoma Service Findings and Recommendations

9.3.1 Pathway – New Patients

In all health boards, most new glaucoma referrals undergo the lowest level (according to NICE guidance) of referral filtering by primary care optometry as part of the Level 2 EHEW/WECS system with repeat measures, although there is variability across areas as to how many optician practices participate which can affect access. Currently it is not known how many patients are seen in this part of the referral filtering which means that it is impossible to ascertain how effective it is and how many unnecessary referrals are avoided both nationally and for each health board.

Referrals come in from the optometrists, and are usually triaged by a consultant or their licensed deputy (e.g. a trained nurse or optometrist or non-consultant doctor). There is a potential higher level referral filtering process through the ODTCs, which are a clinical interface between primary care optometric practice, community services and consultant-led hospital clinic. Following the 2009-10 Focus on Ophthalmology 'All Stakeholders' events, all health boards committed in 2010 to the implementation of the Wales Integrated Care Pathway for Glaucoma for which ODTCs were central. However, the number of sites and whether sites exist is highly variable, the settings vary (optometry practice, community clinic, on the hospital site), the processes and workforce are not nationally standardised, so all health boards will therefore have different procedures and some ODTCs have been closed or reduced in number in recent years; all health boards who had these stated they needed more sites and capacity.

There was variable performance data available for ODTCs where they existed (i.e. how many hospital attendances were avoided). Some health boards had a good grip on this from local audits, some did not, and the rate of discharge after first glaucoma attendance as a proxy measure varied from 0 to 90% as reported in the data pack (although the 90% was acknowledged as improbably high but there was no local data available for us provided to test this). Most of the ODTCs offered a one stop approach for new patients, with diagnostics and assessment undertaken and some management decisions made by the optometrists supported, in some cases, by virtual decision making from the hospital team. The ODTCs were also suffering from a reduced throughput due to Covid infection and prevention control (IPC) restrictions, which the local team felt were no longer needed.

This may not be the most efficient use of these centres. By using the ODTCs primarily as data collection hubs, with more of the assessments and tests done by technicians, HCSWs and assistants (optometry assistant, nursing assistant etc.) rather than registered professionals, and decision making done by the multidisciplinary registered clinical practitioners asynchronously (at a later time), units can significantly increase capacity. We discussed with local teams how to ensure the layout in ODTCs supports high flow data gathering similar to the diagnostic hubs and centres seen in England.

Recommendation 30: NHS Wales to support and encourage all health boards to improve ODTC performance:

- **Increase the numbers of patients seen per session in ODTCs; review and reduce any unnecessary Covid specific infection control practices.**
- **Increase the numbers of patients seen per session by adopting a two stop pathway, separating face to face diagnostics (tests) from the clinical review activity, with the review done later by a MDT clinician or ophthalmologist.**
- **Ensure tests are done by technicians, HCSW's and assistants where possible in all settings, ideally in layouts which support high flow, freeing up the clinicians to be clinical decision makers.**

- **Ensure accurate data (including the discharge rate) is regularly reported on the performance of primary care referral filtering as well as the ODTs to drive improvements.**

9.3.2 Glaucoma Pathway – Follow Ups:

When the new primary eye care contract goes live, there will be much greater potential to transfer or maintain low risk follow ups in primary care optometry and reduce the burden on hospital follow up capacity. It was noted there are also some concerns expressed in the sector about where the responsibility will lie if things go wrong or there is an adverse event within such co-management pathways. However, Swansea has demonstrated, along with similar schemes in England, how successful joined up care pathways can be developed, utilising the range of health care professionals to deliver the pathways within a unified governance framework. It will be a significant challenge to ensure standardisation of quality of diagnostic assessments and equipment across multiple small sites which allow accurate assessment of disease progression over time.

The health boards operate a variable mix of follow ups in ODTs and in the hospital clinic. As happens for new patients, most patients in the ODTs are being seen in one stop face to face pathways. As above, it is far more efficient to have the majority of patients seen in a two stop manner with asynchronous data collection and data review. Up to 70% or more of glaucoma visits can be managed like this, as evidenced by gateway visit data collected by GIRFT in England. In some English units, capacity for a single session might be doubled.

There is a significant concern about patients having access to consultant-led care (see workforce section). There was a lack of written protocols and guidance for staff on how to assess patients, how to grade risk, and which patients should be seen in which sites and clinic types.

There was very significant variability of whether follow up glaucoma patients have a clinical risk stratification recorded and assessed at every visit (RAG i.e. high, medium, low etc. status) and even for those health boards who did grade this, it was not usually available electronically and could not therefore be used to assist prioritising and managing patients at scale, due to the lack of an EPR.

The GIRFT and the RCOphth standard is to have a clinical risk rating recorded for all glaucoma patients; to help direct patients to the right setting, profession and timing of the clinic and to help to plan capacity. The risk rating could be recorded manually in a database in the interim, whilst awaiting OpenEyes, since the implementation date for OpenEyes is not confirmed. **It is critical to manage the demand-capacity of the glaucoma follow up population according to clinical risk, optimising the appropriate deployment of resources. It is unsafe to wait for OpenEyes to facilitate this, since the date for its implementation has not been confirmed.**

Recommendation 31: NHS Wales to support and encourage all health boards to reduce risk and use current resource better for glaucoma patients:

- **Ensure a consistent risk stratification is used for every glaucoma visit, at all sites and for all types of visit, including the greater care in optometry as the contract changes. Use this to create a view of the whole patient population as high, medium & low risk. This should be addressed straight away.**

- **Standard operating procedures, protocols and guidelines for glaucoma should be created and include clinical risk criteria for patients, the specific steps of the operational processes and the pathways, and the clinical decision making and associated governance supporting this.**
- **Implement more diagnostics only clinics with technicians and HCSWs, with later review by the MDT clinical decision makers whether in hospital or ODTc.**

9.3.3 Outpatient Estate and Facilities

There was enormous variability both between and within health boards on the suitability of the buildings and layout for ophthalmology outpatients but overall things were inadequate. Please note we were not able to physically review in detail all the outpatient units.

There was good, fit for purpose dedicated ophthalmology outpatient sites in:

- Bridgend (CTUHB).

There was limited or unsuitable outpatient sites, including access and maintenance issues, old and dated estate, not enough space and poorly organised space in:

- Cardiff (CVUHB)
- Powys (PTHB)
- RGH (CTMUHB)
- Royal Gwent (ABUHB)
- Wrexham Maelor (BCUHB)
- Glangwili General Hospital (HDUHB).
- Swansea (SBUHB) We did not view Swansea outpatient facilities but understand there are issues.

Each health board and unit is struggling to use the outpatient space they have, reconfigure it or obtain more space. Space layout is poor and old fashioned with very inefficient patient flow due to multiple fragmented spaces. We saw many outpatients with poor access for elderly visually impaired people; we saw outpatients with configurations only suitable for general outpatients with no thought for adaptation for the specialist needs for ophthalmology; we saw staff squeezed into small areas, separated from the rest of the ophthalmic service e.g. for pre-op assessments, without access to appropriate modern equipment and consultant oversight. Given the very high volumes of ophthalmology outpatients and surgery, there needs to be enough space with a layout bespoke for ophthalmology flow for modern and efficient theatre and outpatient services, rather than a generic outpatient space. There need to be large waiting areas as we see many patients in a session in clinics. Without this, there will never be a decent possibility of improving capacity and efficiency for the ever-increasing patient demand and to improve patient experience. We noted the difference in staff morale and willingness to undertake improvements was directly proportional to the facilities they had. The poorly maintained and unfit for care areas suggests a de-prioritisation of ophthalmic care from the health boards, despite the very high volume relative to other specialties and the long waits, and a lack of senior support for and/or interest in the service.

The lack of space could be helped to an extent by undertaking some consultations remotely i.e. by video or telephone consultation after the diagnostic data has been collected. Many health boards felt this would be difficult and that remote consultations would only work if they

had an EPR rather than the current paper notes which cannot leave the hospital site. However, it was pointed out that for staff working in hospital and potentially ODTG staff, this could be done using non-clinical rooms on site as long as the clinical data was visible in such rooms.

Recommendation 32: NHS Wales to support and encourage all health boards to improve use of existing estate:

- **Explore the use of asynchronous virtual clinics with written confirmation of results to the patient or, if more appropriate, with remote video or telephone consultations after diagnostic data collection. Do the virtual reviews in non-clinical rooms as long as the clinicians can access the notes and diagnostics/imaging data.**
- **Review the footprint and usage of all the current and potentially available new space in outpatient areas and create subspecialist areas with teams and all equipment in one area for glaucoma.**
- **Improve the facilities, access and parking of the eye units where possible. Sort out the décor and repair within current facilities. Support the staff to reassess and improve the space use; remove extraneous equipment and extraneous staff and tasks from small spaces.**

Nearly all the local teams felt that their outpatient space will always be limited and not suitable for modern high flow ophthalmic care in light of the ever-increasing demand. They were keen to see investment to support regional centres of excellence as a resource for the health boards in the region, combined with the flexible use of the workforce.

9.3.4 Glaucoma Workforce

Across the UK there is a national shortage of ophthalmology consultants, and glaucoma is particularly badly affected. Wales is struggling more than England to attract glaucoma consultants particularly in certain health boards; Swansea, Cardiff, CTMUHB and ABUHB are better able to attract consultants than Hywel Dda and Betsi. Powys would like to recruit but previous attempts for joint appointments have not succeeded.

Most of the units we saw did not have enough glaucoma consultants to deliver the service and certainly not to develop the service, so that there are long backlogs and with little hope of consultant leadership to develop the service to reduce this as consultants are busy firefighting or being overwhelmed by patient numbers in clinic. There are many patients being seen in general clinics by generalist consultants, or by generalist non consultants such as specialty doctors, SAS (staff grade and associate specialist) and trainee doctors without good glaucomatologist oversight. We are aware that without consultant supervision such doctors often do not make definitive decisions and patients fail to be discharged or get overly followed up. In some health boards, such as Hywel Dda, there were serious concerns that most patients are simply not under the care or responsibility of any substantive ophthalmology consultant on the specialist register at all which is unsafe.

The peer reviewed publication "[Tackling the NHS glaucoma clinic backlog](#)" by Broadway and Tibbenham in Eye 2019 illustrates the positive effects of subspecialist consultant input. Consultants with an interest in glaucoma reviewed over 9000 glaucoma case notes in the Norfolk and Norwich University Hospital and found many patients needing hospital care could have their reviews safely deferred or visual field tests avoided, and many more could be discharged to specialist or non-specialist community optometrists. Altogether 26% of their patients were discharged from their hospital eye service.

Recommendation 33: NHS Wales to support and encourage all health boards to audit their glaucoma practice and see whether patients are being overly followed up, not discharged or not managed well, to inform any business case for more consultants or other practitioners to replace them.

The potential for utilising the MDT has not been fulfilled. Some units are doing more than others but it is a struggle even for them to develop the team as they wish to, and they have not been granted funding and support for this. There are many opportunities for more glaucoma higher qualified optometrists, orthoptists and nurse practitioners to be trained and to themselves deliver training, and thus overall deliver more glaucoma care. There are also many primary care optometrists who have or could develop higher qualifications but struggle to access training and placements in hospital due to limitations of space and very limited consultant time to be able to develop them or accommodate them in the clinics. In addition, there is still too much utilisation of registered staff for undertaking simple assessments such as vision, simple questions, pressures and imaging tests. With limitations in consultant numbers, it is crucial to develop a team of MDT decision makers working with them if there is any hope of increasing capacity.

There is a definite need to consider how to ensure, in hospital, primary care and in the ODTs, that registered clinicians are not used to collect data or perform imaging or repeatable simple tasks such as vision and IOP, but are used for clinical decision making; therefore, more technicians and HSCWs are needed for those lower level tasks. Consultants are then not making regular decisions on low risk and straightforward cases and can concentrate on managing the complex cases, training and developing the service.

Recommendation 34: NHS Wales to support and encourage all health boards to undertake a comprehensive review of the roles, job plans, the numbers and professional development of the MDT, in the glaucoma services in hospital and the ODTs. Utilise the capabilities of non-medical staff to the maximum so that the consultants can concentrate on the complex cases, training and service improvement.

9.3.5 Delays

Wales was the first UK country to have a national target for ophthalmic follow up patients combined with a risk rating (R1 are high risk, all glaucoma are R1). The target is 95% of R1 patients are seen within 125% of their intended target time.

In all health boards there were variable but significant backlogs, and no health board is near achieving this target. For many, there were regular backlogs of a year past their planned review date with up to four years for some glaucoma patients. In some health boards, e.g. Hywel Dda, it was absolutely routine to see glaucoma follow ups years after the target date. Data was poor. Many health boards admitted that they did not have access to accurate data to manage their capacity and plans for recovery. Validation processes were cumbersome. Long delayed follow up patients were re-referred by their optometrist thus duplicating records as the same patient was coded as both a new and a follow up. There was concern that the data presented in many health boards seemed to not reflect the day to day experience of the clinical team, and there were instances where managers and clinicians could not agree what the real extent of delay was.

Primary care optometry colleagues present, confirmed that the delays were on the worse side. Health boards had a real desire to demonstrate that they could fulfil the governmental targets to reduce delays which sometimes led to over optimistic assumptions and unrealistic dates for improvement. Only one or two health boards had any sort of data-led trajectory for elimination of the backlogs dependent on different options for service improvement, but often no convincing evidence that any of these options would be deliverable. There was a failure of any robust demand and capacity work to address outpatient ophthalmology for now and the future population need which meant that high quality business cases could not be put together. Overall, there are many thousands of glaucoma follow ups in Wales waiting dangerously long times to be seen with no real grasp of their current levels of clinical risk and no convincing plan that change will occur to meaningfully reduce these delays. Glaucoma is a silently (asymptomatic until too late) progressive disease and once vision is lost it can never be regained. We suspect Wales is sitting on a time bomb of irreversible sight loss in large numbers of patients.

There was great frustration that often there were multiple small things which, if sorted out, could add value, such as non-working visual field machines, incorporating a primary care optometrist into the clinic, sorting out EPR bugs, addressing small estate issues etc.; it was felt that essentially nothing happens when these things are raised. This was a combination of everyone being so busy coping with the backlog that there is no time to undertake anything else, a lack of consultant manpower to lead and improve the service and a lack of support from health board leaders.

Overall, there is no strategic capacity and demand approach for the current and future glaucoma care need and there is great local concern, which we share, that there is no robust plan which gives confidence that current capacity will be able to eliminate the unsafe backlogs and, if so, by when. The Welsh government are likely to need to see that services are maximised in terms of provision and that appropriate modelling of what is needed has been done, before additional funding is provided.

Recommendation 35: NHS Wales to support and encourage all health boards to reduce unsafe delays and improve glaucoma capacity:

- **Accelerate as much as possible the efficiency and staff changes required, using the recommendations in this report, to eliminate the glaucoma backlog earlier than 2025.**
- **The very long waiters need to be assessed now (e.g. by virtual assessments) regardless of the original risk rating to avoid avoidable cases of serious harm.**
- **Urgently address ensuring the data for glaucoma activity and delays are accurate and rapidly introduce regular validation processes.**
- **Urgent capacity and demand work for the current glaucoma backlog, with an honest assessment of the situation, and production of a strategic demand and capacity, workforce and funding plan to attain a sustainable model for glaucoma services.**

9.3.6 Failsafe

Some health boards had failsafe officers, or similar glaucoma coordinators, and some did not; few had a written process to underpin this. A number of health boards were not completely sure what failsafe meant. A failsafe officer is a key recommendation to minimise risk of sight loss from ophthalmic outpatient delays by [RCOphth](#)/GIRFT, the Health Safety Investigation

Branch ([HISIB](#)) and [NHS England](#). It is worth noting that some health boards had a failsafe officer in place but, without any options to increase capacity, it was difficult for them to add any value to protect patients.

Recommendation 36: NHS Wales to support and encourage all health boards to appoint a dedicated failsafe officer and have a documented process/SOP with an escalation process for glaucoma and other high risk ophthalmic disease.

DRAFT

10 Annex A: Schedule of visits

Health Board	Site	Date
Aneurin Bevan University Health Board	Royal Gwent Hospital	15th June
	Glaucoma VIRTUAL deep dive	19th June
Betsi Cadwaladr	Wrexham Hospital	21st March
	Abergele Hospital	22nd March
	Ysbyty Gwynedd Hospital	4th April
	Glaucoma VIRTUAL deep dive	13th June
Cardiff and Vale university health board	Glaucoma VIRTUAL deep dive	5th June
	UHW Cardiff	8th June
Cwm Taf Morgannwg University Health Board	Glaucoma VIRTUAL deep dive	30th May
	Royal Glamorgan Hospital	7th June
	Princess of Wales Hospital	7th June
Hywel Dda University Health Board	Glangwili General Hospital	28 th /29th June
	Glaucoma VIRTUAL deep dive	11th July
Powys Teaching Health Board	Llandrindod Wells Community Hospital	16th June
	Brecon War Memorial Hospital	16th June
	Cataract VIRTUAL deep dive	22nd June
	Glaucoma VIRTUAL deep dive	3rd July
Swansea Bay University Health Board	Singleton Hospital	6th June
	Glaucoma VIRTUAL deep dive	12th June

11 Annex B: List of useful resources

1. GIRFT Ophthalmology Report
2. GIRFT Ophthalmology Guidance
3. GIRFT/OPRT outpatient guidance 'Tackling demand for outpatient appointments'
4. GIRFT/RCOphth High Flow Cataract Surgery
5. Patient Guidance for Drops self-instillation
6. RCOphth EPR Standards
7. RCOphth ophthalmic imaging guidance
8. NOD national cataract audit including PCR Adjustment and visual acuity outcomes
9. Standards & Guidance | The Royal College of Ophthalmologists (rcophth.ac.uk)
10. UK Ophthalmology Alliance - UK Ophthalmology Alliance (uk-oa.co.uk)
11. Policy packs and competencies and case studies for non-medical ophthalmic healthcare professionals
 - a. UKOA Cataract non-medical practice pack
 - b. UKOA Surgery Roles Policy
 - c. UKOA SLT and PI laser practice pack
12. RCOphth/UKOA Consenting guidance/standards
13. UKOA/RCOphth Cataract Consent Form
14. WHO Cataract Checklist Form
15. GIRFT Shared Decision Making Aid for Cataract Surgery during Covid Recovery
16. NHS England Shared Decision Making Aid for Cataract Surgery
17. RCOphth/UKISCRS IBCS guidance and related webinar
18. UKOA/RCOphth IOL guidance
19. The-Management-of-Angle-Closure-Glaucoma-Clinical-Guidelines.pdf (rcophth.ac.uk)
20. Lack of timely monitoring of patients with glaucoma — HSIB
21. There are also miscellaneous documents stored here relevant to the report Publications - UK Ophthalmology Alliance (uk-oa.co.uk)

Ophthalmology Activity Data Review

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Background

As per the approved Clinical Services Plan methodology, high level activity between 1 April 2018 and 31st July 2023 has been included for Ophthalmology Services at:

- Cardigan Integrated Care Centre
- Amman Valley Hospital
- North Road Clinic (Aberystwyth)
- Aberaeron Hospital/ Integrated Care Centre
- Bronglais Hospital
- Withybush Hospital
- Glangwili Hospital
- Prince Philip Hospital
- South Pembrokeshire Hospital (Outpatient Interactions only)

Conditions, treatments, and services within Ophthalmology included are:

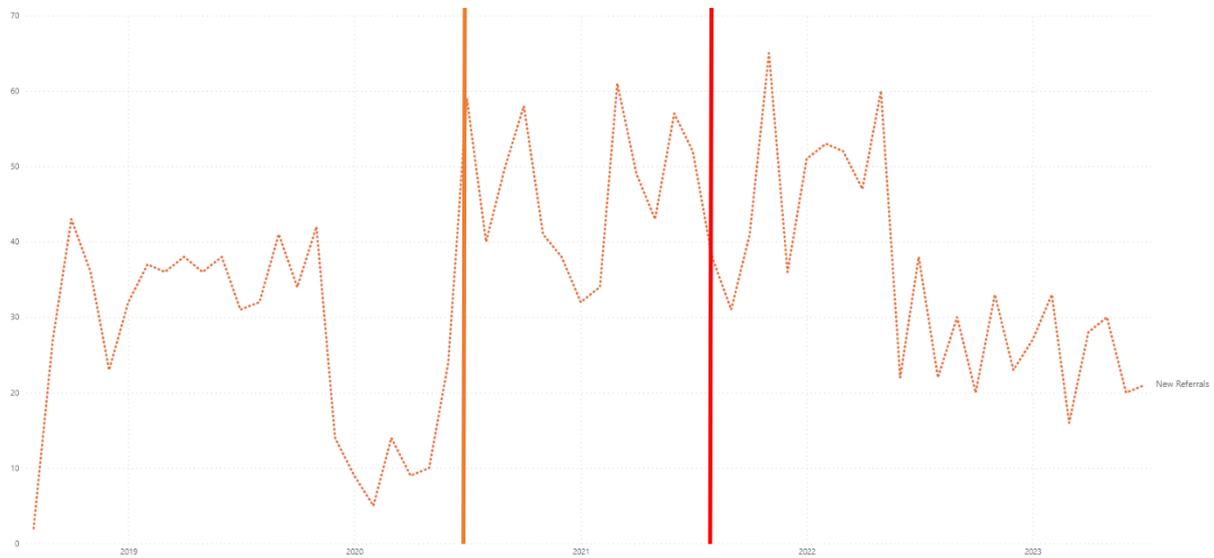
- Cataract
- Glaucoma
- Cornea
- Adult Motility
- Paediatrics
- Oculoplastic
- Orbit
- Vitreo Retinal
- Medical Retina
- Hydroxychloroquine retinopathy (HCQ)
- Other (General, Chemo, Infection, Inflammation)
- Diabetic Retinopathy

There is also data present for several other locations across the Health Board, and where relevant, any Outsourced location. The information in this document is accurate as of quarter 3, 2023/24

The temporary services change in response to COVID commenced April 16, 2020, and is reflected by a vertical blue line. The service changes were ratified during May public board and is shown in the graph by a vertical red line. The summary of the service change is as follows:

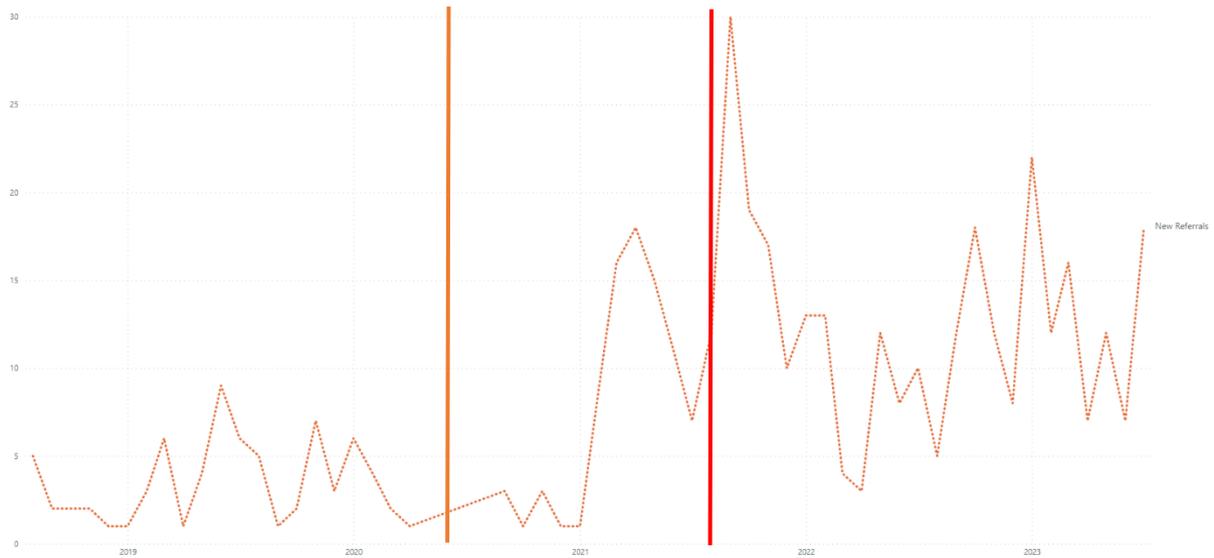
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan & District Hospital	96	89	1	0	0	0	186
Cardigan Integrated Care Centre	0	3	12	58	58	14	145
Total	96	92	13	58	58	14	331

Amman Valley Hospital Outpatient Referrals 01 August 2018 – 31 July 2023



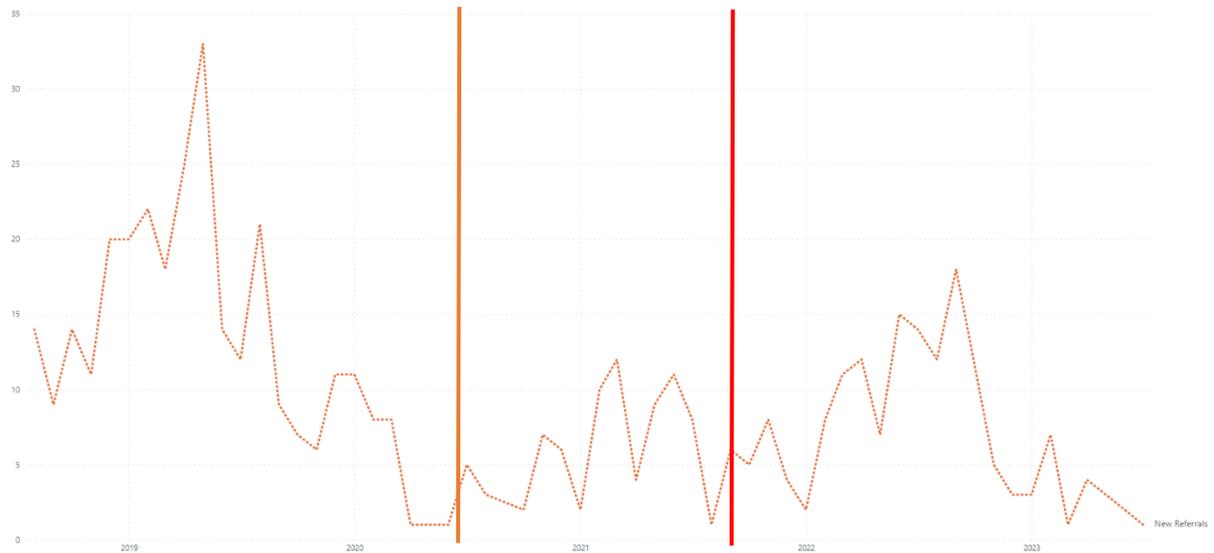
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Amman Valley Hospital	236	334	456	568	371	101	2,066
Total	236	334	456	568	371	101	2,066

North Road Clinic, Outpatient Referrals 01 August 2018 – 31 July 2023



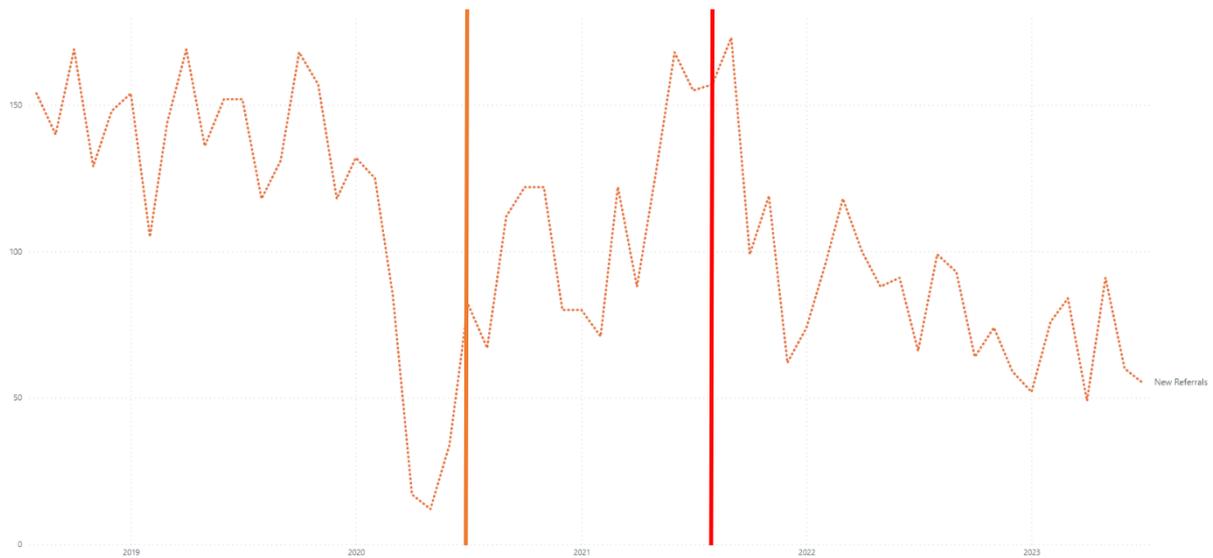
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
North Rd Aberystwyth	22	50	35	169	138	46	460
Total	22	50	35	169	138	46	460

Aberaeron Hospital/Aberaeron Integrated Care Centre, Outpatient Referrals 01 August 2018 – 31 July 2023



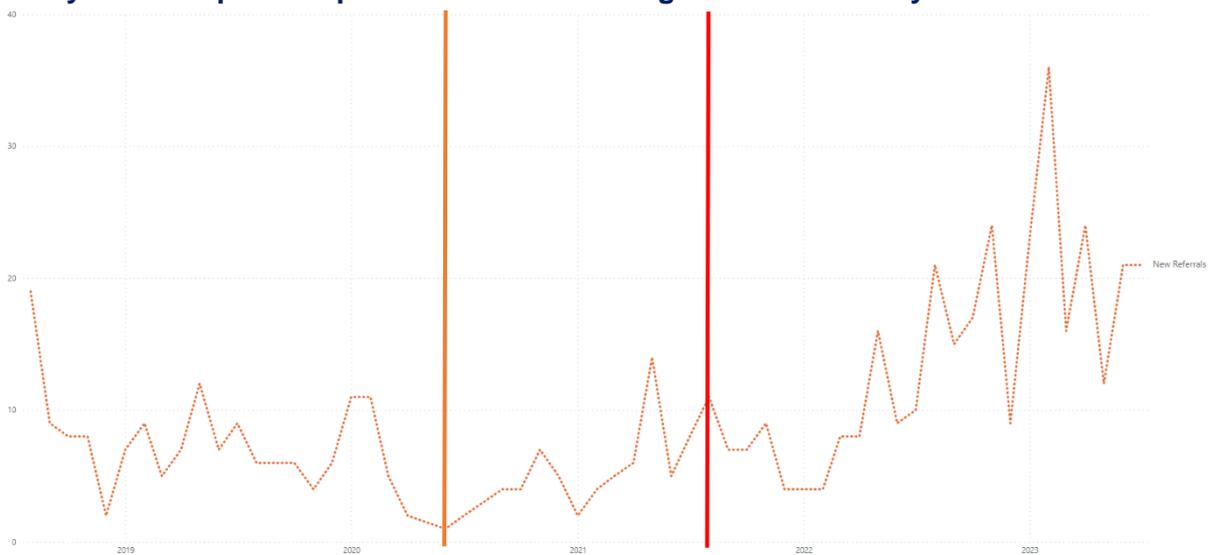
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Aberaeron Hospital	128	149	16	2	0	0	295
Aberaeron Integrated Care Centre	0	16	34	75	102	8	235
Total	128	165	50	77	102	8	530

Bronglais Hospital, Outpatient Referrals 01 August 2018 – 31 July 2023



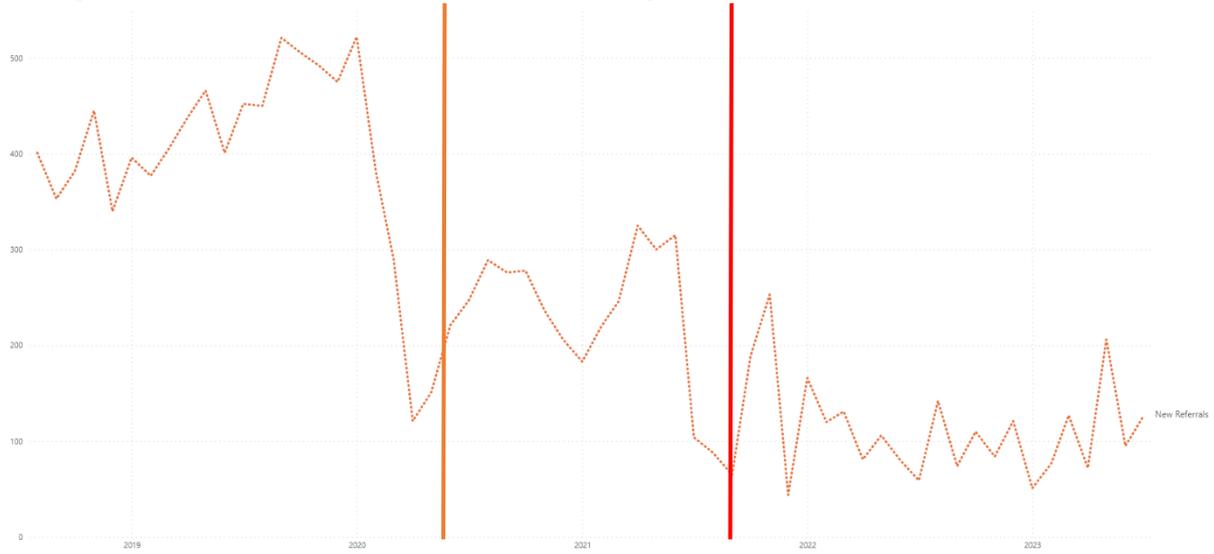
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Bronglais General Hospital	1,143	1,643	921	1,435	961	283	6,386
Total	1,143	1,643	921	1,435	961	283	6,386

Withybush Hospital Outpatient Referrals 01 August 2018 – 31 July 2023



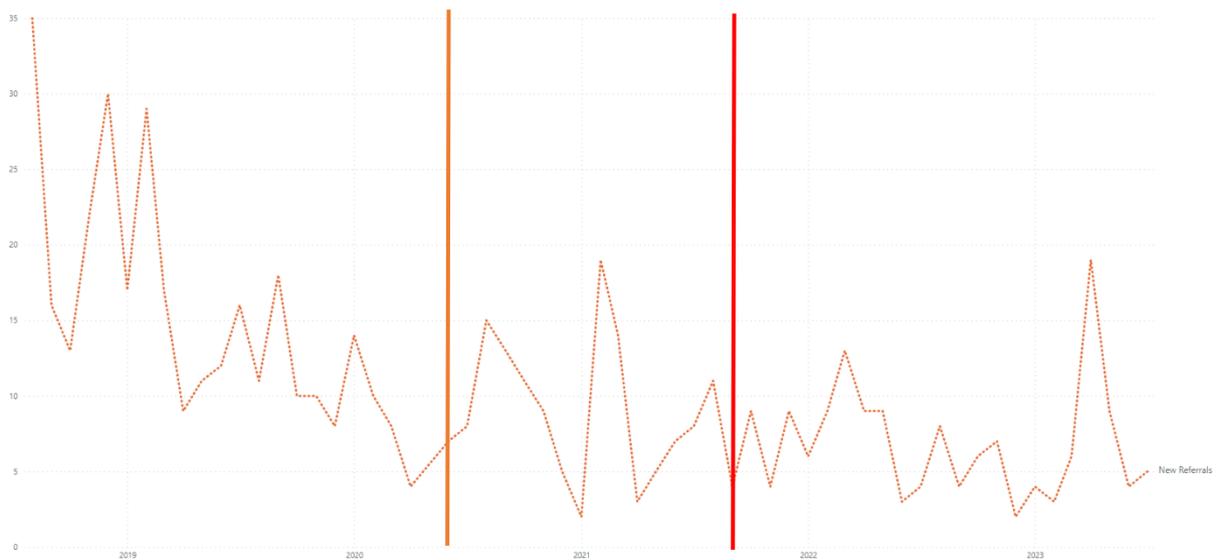
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Withybush General Hospital	67	90	39	87	205	79	567
Total	67	90	39	87	205	79	567

Glangwili Hospital Outpatient Referrals 01 August 2018 – 31 July 2023



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
☒ Glangwili General Hospital	3,098	5,394	2,674	2,100	1,114	503	14,883
Total	3,098	5,394	2,674	2,100	1,114	503	14,883

Prince Philip Hospital Outpatient Referrals 01 August 2018 – 31 July 2023



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
☒ Prince Philip Hospital	179	137	107	88	65	37	613
Total	179	137	107	88	65	37	613

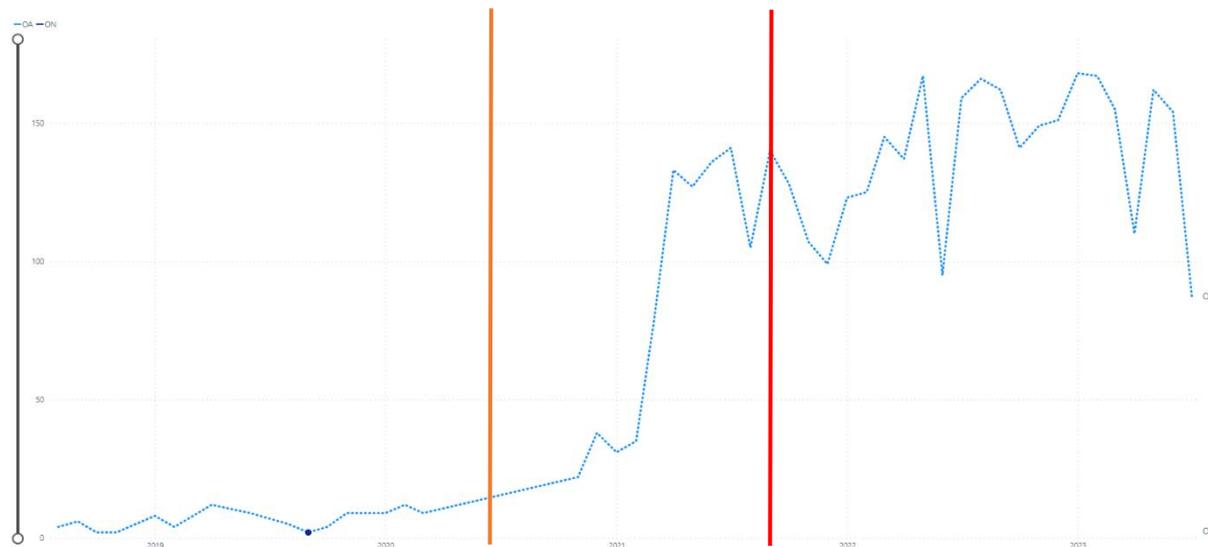
All sites Outpatient Referrals 01 August 2018 – 31 July 2023



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
⊕ Aberaeron Hospital	128	149	16	2	0	0	295
⊕ Aberaeron Integrated Care Centre	0	16	34	75	102	8	235
⊕ Amman Valley Hospital	236	334	456	568	371	101	2,066
⊕ Bronglais General Hospital	1,143	1,643	921	1,435	961	283	6,386
⊕ Cardigan & District Hospital	96	89	1	0	0	0	186
⊕ Cardigan Integrated Care Centre	0	3	12	58	58	14	145
⊕ Glangwili General Hospital	3,098	5,394	2,674	2,100	1,114	503	14,883
⊕ North Rd Aberystwyth	22	50	35	169	138	46	460
⊕ Prince Philip Hospital	179	137	107	88	65	37	613
⊕ Werndale Hospital	0	0	10	0	0	0	10
⊕ Withybush General Hospital	67	90	39	87	205	79	567
Total	4,969	7,905	4,305	4,582	3,014	1,071	25,846

Outpatient Interactions Charts

Cardigan Integrated Care Centre Outpatient Referrals 01 August 2018 – 31 July 2023



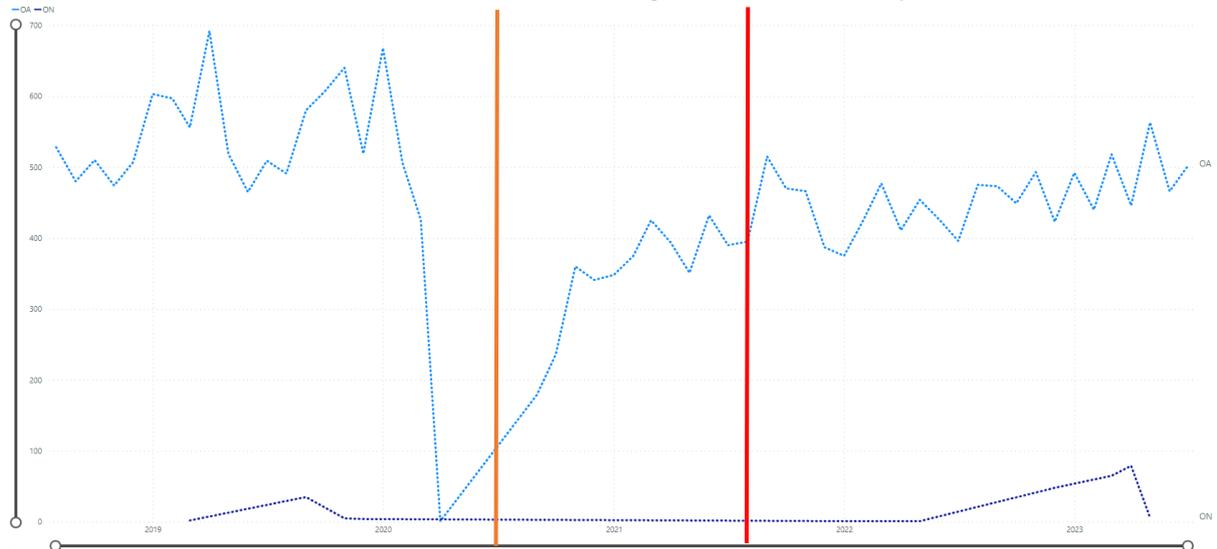
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Cardigan & District Hospital	26	46	0	0	0	0	72
Cardigan Integrated Care Centre	0	36	204	1,509	1,817	512	4,078
Total	26	82	204	1,509	1,817	512	4,150

Amman Valley Hospital Outpatient Referrals 01 August 2018 – 31 July 2023



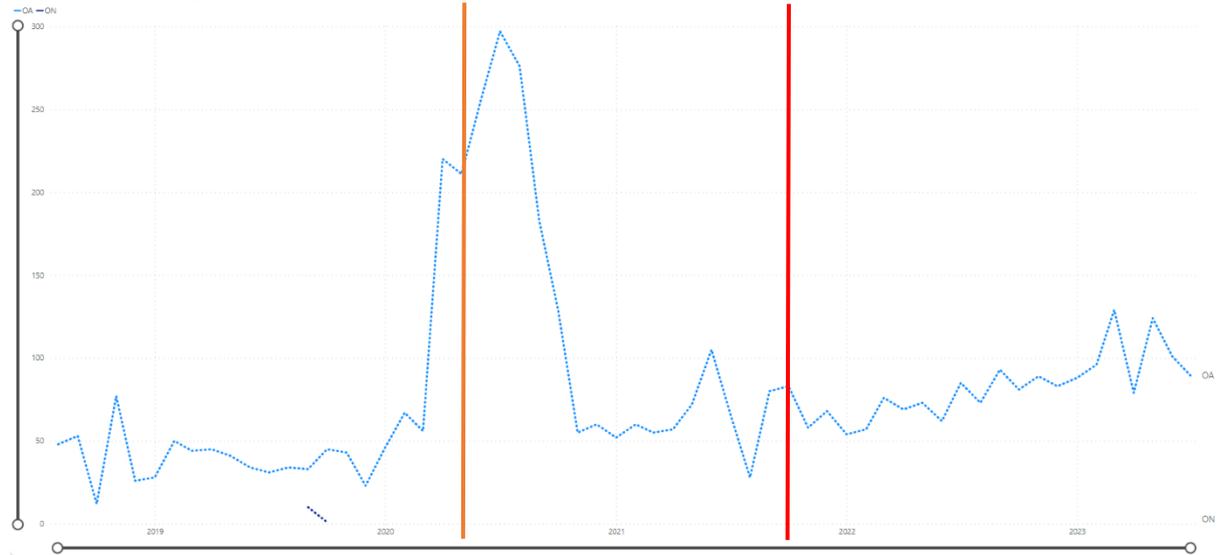
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Amman Valley Hospital	642	1,057	1,573	1,370	1,166	267	6,075
Total	642	1,057	1,573	1,370	1,166	267	6,075

North Road Clinic, Outpatient Referrals 01 August 2018 – 31 July 2023



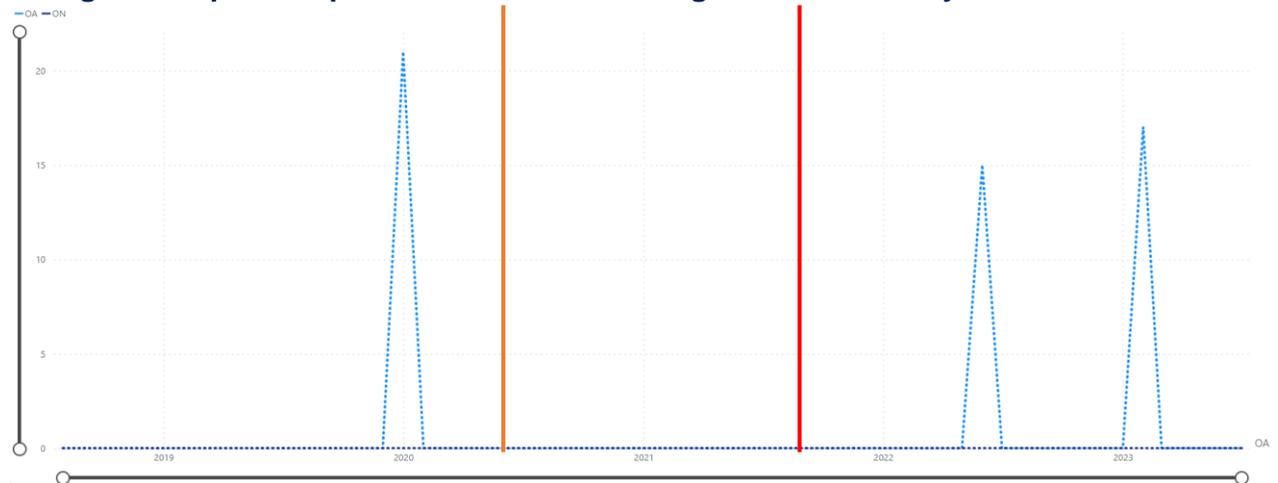
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
North Rd Aberystwyth	4,257	6,666	2,265	5,079	5,564	2,063	25,894
Total	4,257	6,666	2,265	5,079	5,564	2,063	25,894

Aberaeron Hospital/Aberaeron Integrated Care Centre, Outpatient Referrals 01 August 2018 – 31 July 2023



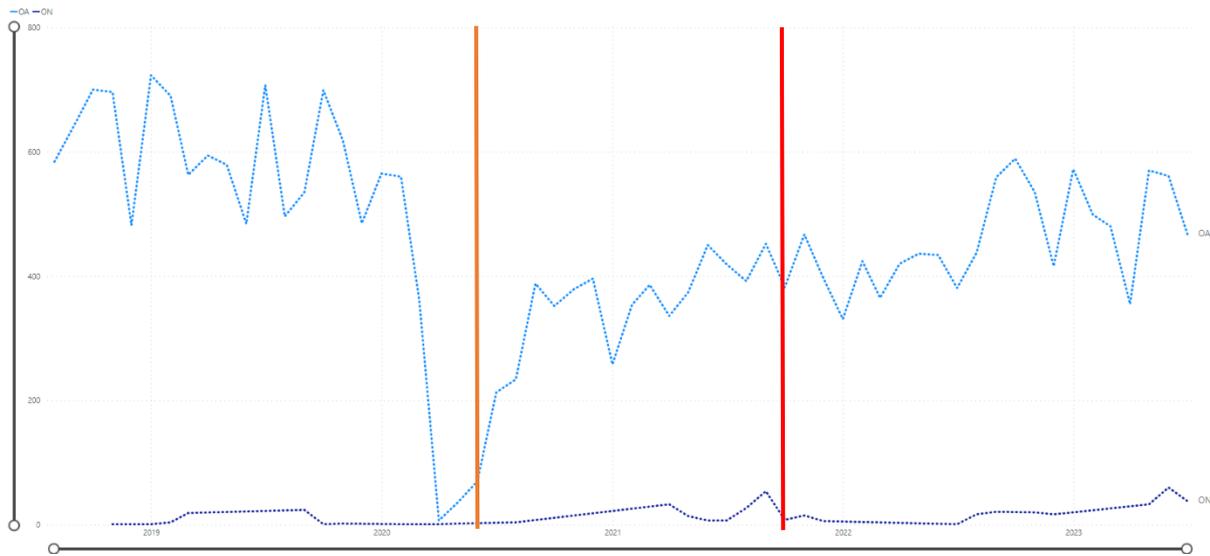
Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Aberaeron Hospital	338	255	0	0	0	0	593
Aberaeron Integrated Care Centre	0	254	1,854	804	1,021	393	4,326
Total	338	509	1,854	804	1,021	393	4,919

Bronglais Hospital Outpatient Interactions 01 August 2018 – 31 July 2023



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Bronglais General Hospital	0	21	0	0	32	0	53
Total	0	21	0	0	32	0	53

Withybush Hospital Outpatient Interactions 01 August 2018 – 31 July 2023

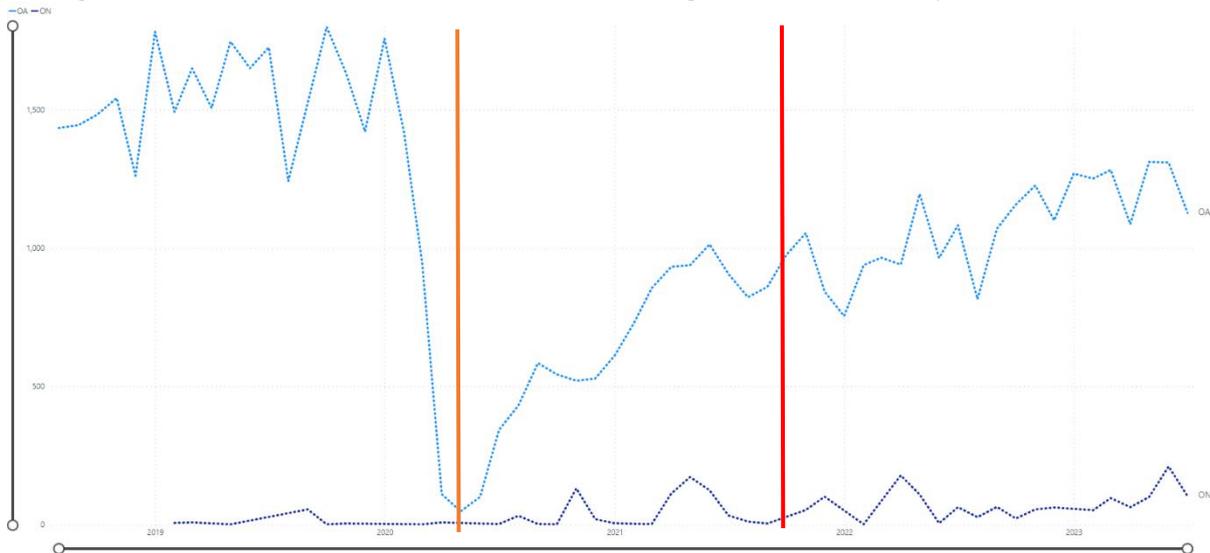


Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Withybush General Hospital	5,103	6,710	3,080	4,960	5,855	2,085	27,793
Total	5,103	6,710	3,080	4,960	5,855	2,085	27,793

OA – face to face appointment

ON – online appointment

Glangwili Hospital Outpatient Interactions 01 August 2018 – 31 July 2023

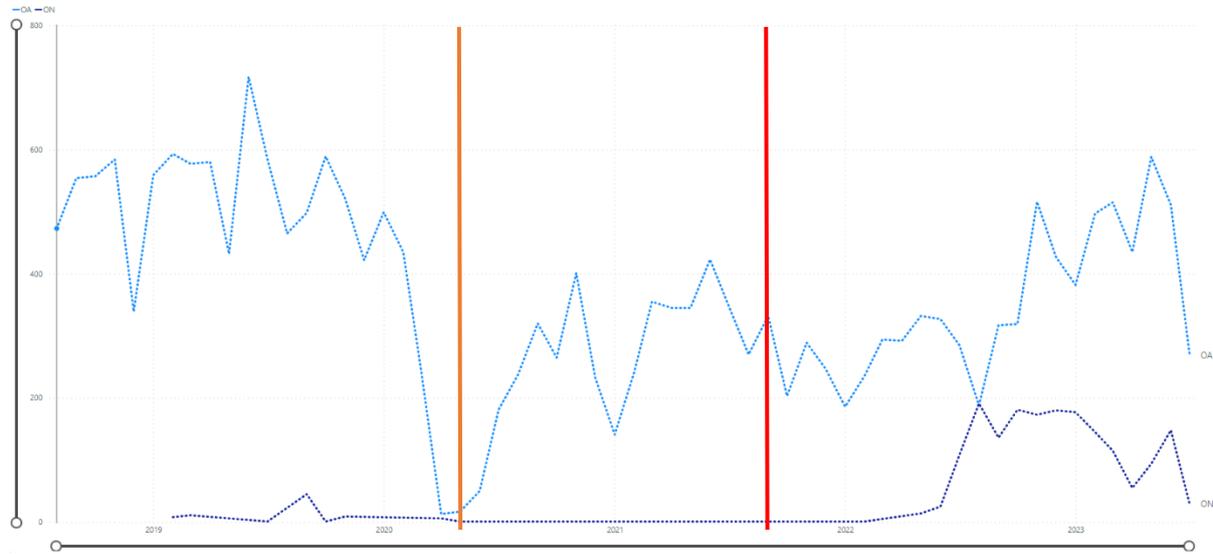


Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Glangwili General Hospital	12,100	18,426	5,608	11,610	14,142	5,309	67,195
Total	12,100	18,426	5,608	11,610	14,142	5,309	67,195

OA – face to face appointment

ON – online appointment

Prince Philip Hospital Outpatient Interactions 01 August 2018 – 31 July 2023

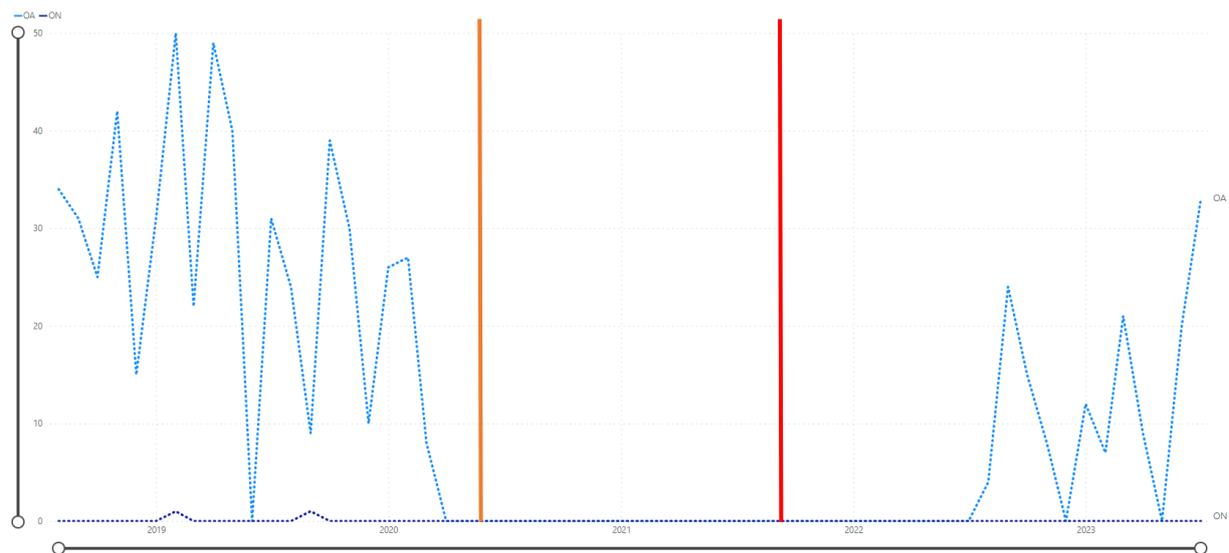


Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Prince Philip Hospital	4,253	6,037	2,464	3,520	5,842	2,126	24,242
Total	4,253	6,037	2,464	3,520	5,842	2,126	24,242

OA – face to face appointment

ON – online appointment

South Pembrokeshire Hospital Outpatient Interactions 01 August 2018 – 31 July 2023

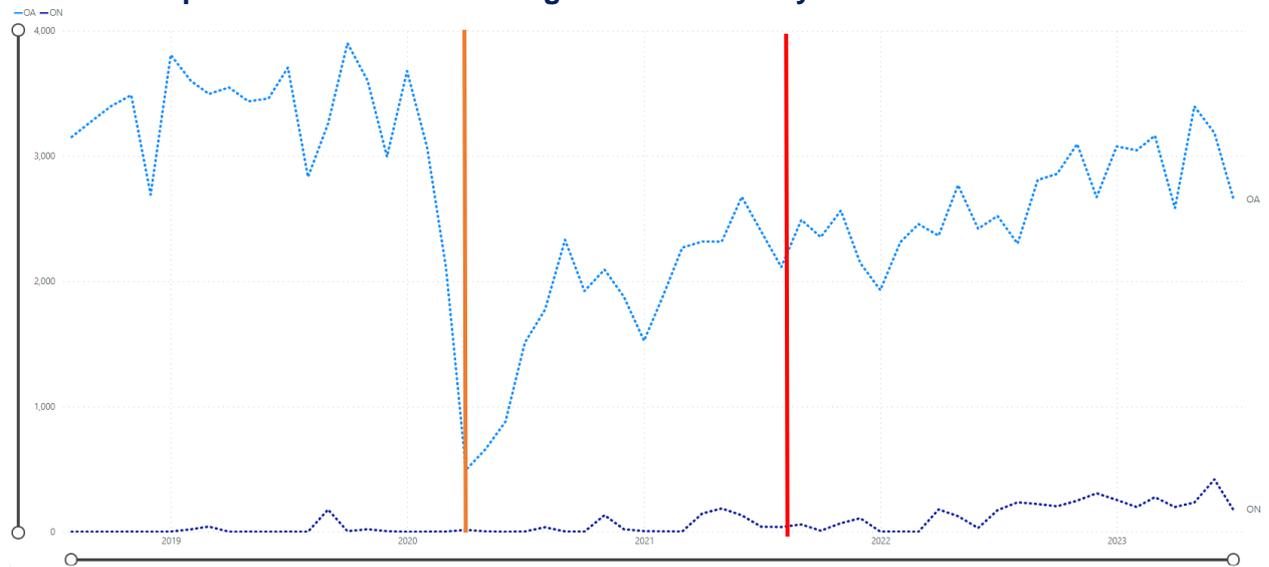


Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
South Pembrokeshire Hospital	251	294	0	0	91	62	698
Total	251	294	0	0	91	62	698

OA – face to face appointment

ON – online appointment

All sites Outpatient Interactions 01 August 2018 – 31 July 2023



Hospital Site/Clinical Condition	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
⊕ Aberaeron Hospital	338	255	0	0	0	0	593
⊕ Aberaeron Integrated Care Centre	0	254	1,854	804	1,021	393	4,326
⊕ Amman Valley Hospital	642	1,057	1,573	1,370	1,166	267	6,075
⊕ Bronglais General Hospital	0	21	0	0	32	0	53
⊕ Cardigan & District Hospital	26	46	0	0	0	0	72
⊕ Cardigan Integrated Care Centre	0	36	204	1,509	1,817	512	4,078
⊕ Glangwili General Hospital	12,100	18,426	5,608	11,610	14,142	5,319	67,205
⊕ North Rd Aberystwyth	4,257	6,666	2,265	5,079	5,564	2,063	25,894
⊕ Prince Philip Hospital	4,253	6,037	2,464	3,520	5,843	2,126	24,243
⊕ South Pembrokeshire Hospital	251	294	0	0	91	62	698
⊕ Werndale Hospital	0	0	2,403	0	0	0	2,403
⊕ Withybush General Hospital	5,103	6,710	3,080	4,960	5,855	2,085	27,793
Total	26,970	39,802	19,451	28,852	35,531	12,827	163,433

OA – face to face appointment

ON – online appointment

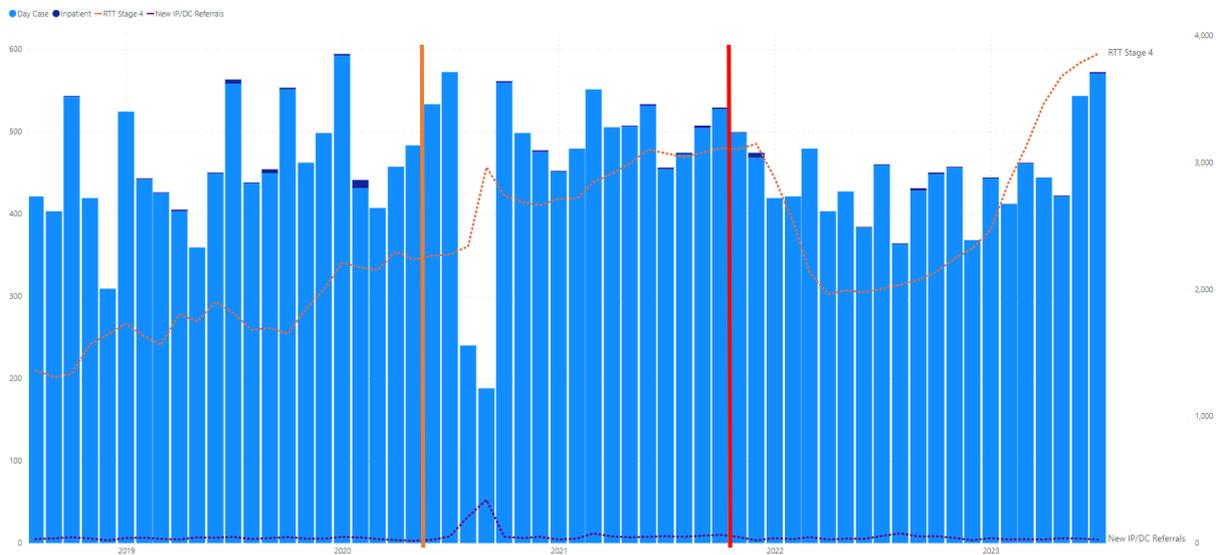
Inpatient and Day Case Activity Charts

Amman Valley Activity 01 August 2018 – 31 July 2023

Inpatient & Day Case Referrals

ReferralOutcome	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day case list	289	477	948	562	497	131	2,904
DayCase Admission	0	2	0	0	0	0	2
InPatient Admission	0	0	0	0	0	0	0
Inpatient list	0	0	0	0	0	0	0
Total	289	479	948	562	497	131	2,906

Inpatient & Day Case Activity



TreatmentManagement	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day Case	3,485	5,596	5,486	5,784	5,052	1,978	27,381
Inpatient	3	28	5	19	11	3	69
Total	3,488	5,624	5,491	5,803	5,063	1,981	27,450

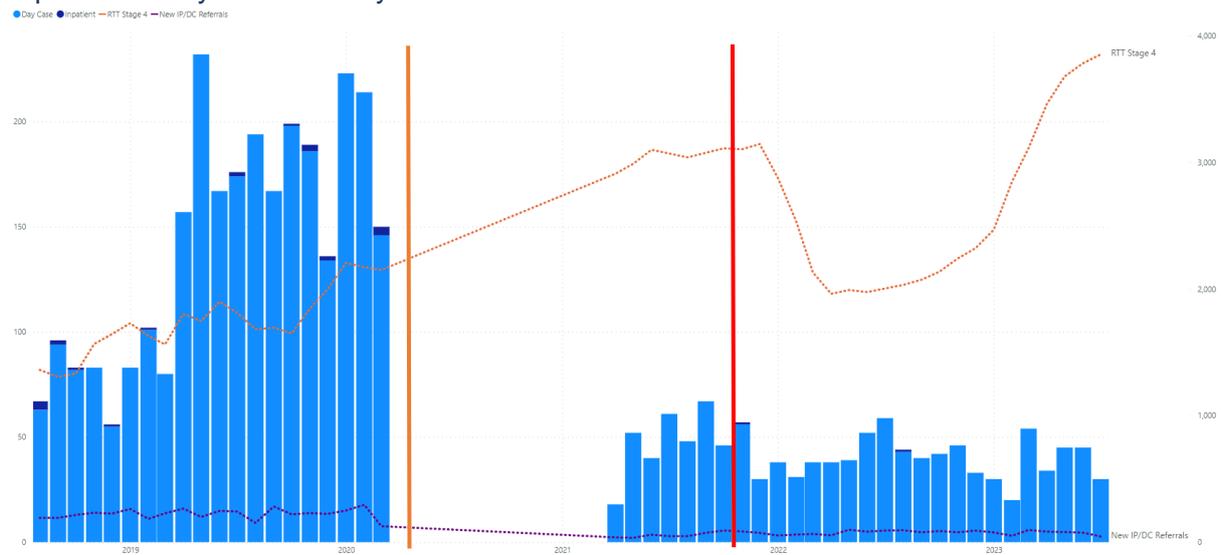
Bronglais Hospital activity 01 August 2018 – 31 July 2023

RTT – Return to Treatment

Inpatient & Day Case Referrals

ReferralOutcome	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day case list	759	974	183	729	990	291	3,926
DayCase Admission	971	1,756	0	0	0	0	2,727
InPatient Admission	0	1	0	0	0	0	1
Inpatient list	1	0	1	0	0	0	2
Total	1,731	2,731	184	729	990	291	6,656

Inpatient & Day Case Activity



TreatmentManagement	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day Case	641	2,192	0	525	496	154	4,008
Inpatient	9	12	0	1	1	0	23
Total	650	2,204	0	526	497	154	4,031

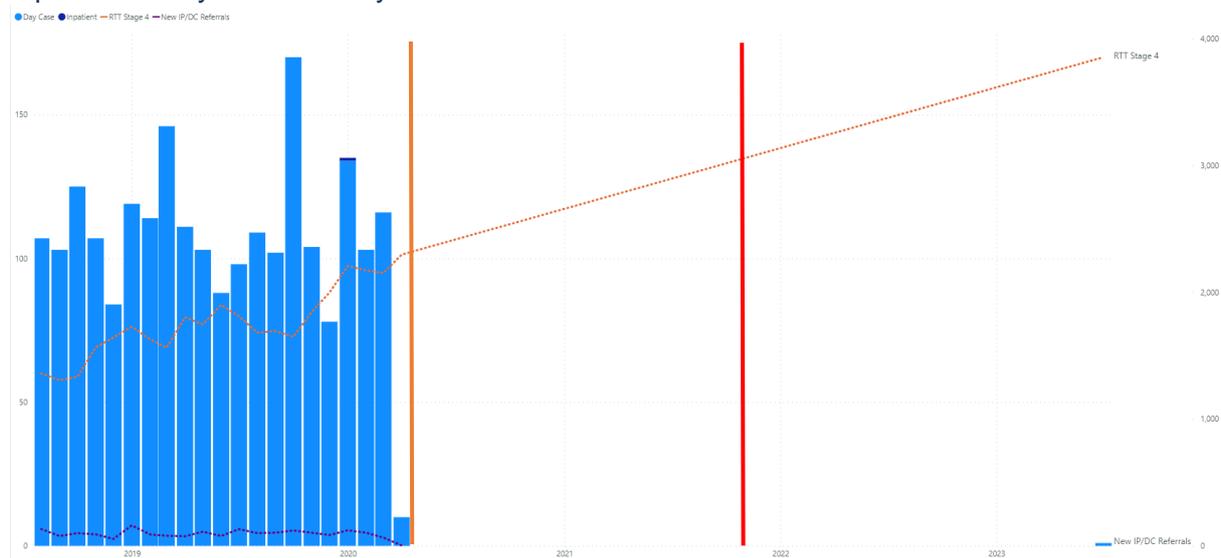
Withybush Hospital activity 01 August 2018 – 31 July 2023

RTT – Return to Treatment

Inpatient & Day Case Referrals

ReferralOutcome	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day case list	790	1,208	5	3	6	3	2,015
DayCase Admission	0	0	0	0	0	0	0
InPatient Admission	0	0	0	0	0	0	0
Inpatient list	0	0	0	0	0	0	0
Total	790	1,208	5	3	6	3	2,015

Inpatient & Day Case Activity



TreatmentManagement	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day Case	905	1,316	10	0	0	1	2,232
Inpatient	0	1	0	0	0	0	1
Total	905	1,317	10	0	0	1	2,233

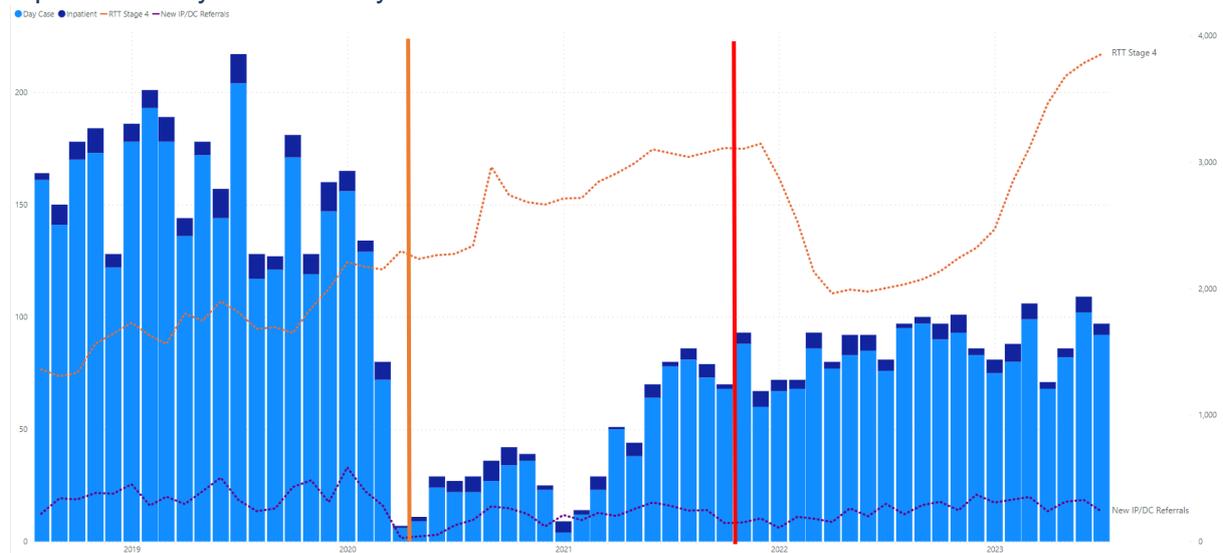
Glangwili Hospital activity 01 August 2018 – 31 July 2023

RTT – Return to Treatment

Inpatient & Day Case Referrals

ReferralOutcome	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day case list	2,745	4,513	1,895	2,502	3,408	1,146	16,209
DayCase Admission	0	2	9	4	9	3	27
InPatient Admission	0	0	0	0	0	0	0
Inpatient list	6	8	2	3	7	1	27
Total	2,751	4,523	1,906	2,509	3,424	1,150	16,263

Inpatient & Day Case Activity



TreatmentManagement	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day Case	1,316	1,688	242	821	1,033	344	5,444
Inpatient	64	111	55	56	68	19	373
Total	1,380	1,799	297	877	1,101	363	5,817

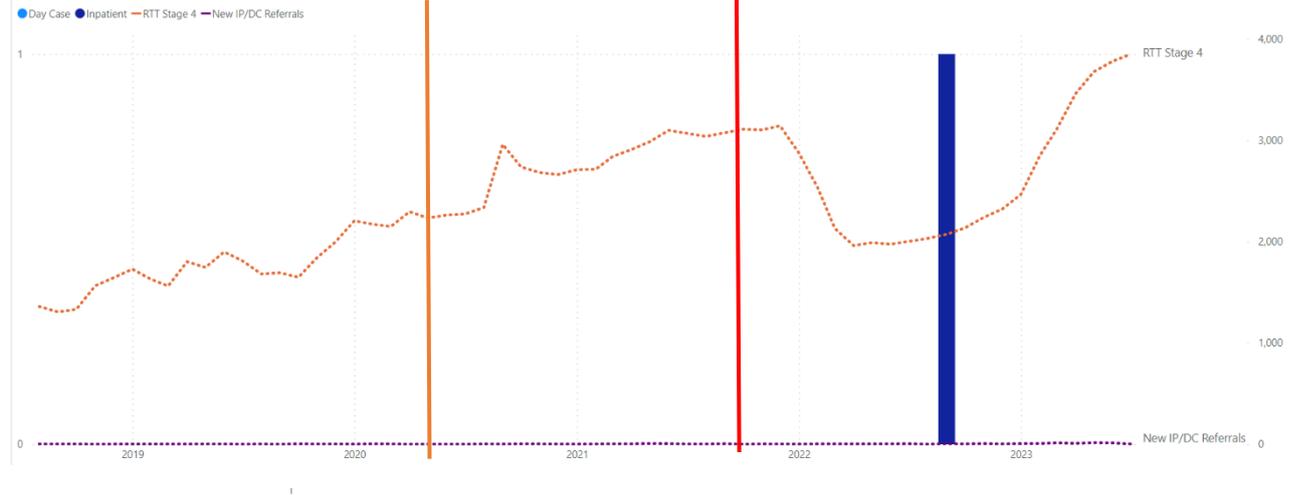
Prince Philip Hospital activity 01 August 2018 – 31 July 2023

RTT – Return to Treatment

Inpatient & Day Case Referrals

ReferralOutcome	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Day case list	10	23	19	39	60	34	185
DayCase Admission	0	0	0	0	0	1	1
InPatient Admission	0	0	0	0	0	0	0
Inpatient list	0	0	1	0	2	6	9
Total	10	23	20	39	62	41	195

Inpatient & Day Case Activity



TreatmentManagement	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	2023/2024	Total
Inpatient	0	0	0	0	1	0	1
Day Case	0	0	0	0	0	0	0
Total	0	0	0	0	1	0	1

Outsourced Data

The outsourced activity table below highlights the number of activities which have been outsourced by the Health Board (A patient may have more than one activity). Due to the nature of how this data is captured we have represented this in financial year form between 1 April 2018 - 31 March 2023. Which varied from the remainder of the activity data as highlighted throughout this document.

Year	Point of Delivery	Provider	Sum of No of Activities
18/19	Daycase	BMI Bath	91
		BMI Werndale	2,022
		Nuffield	76
	Daycase Total		2,189
18/19 Total			2,189
19/20	Daycase	BMI Werndale	1,679
	Daycase Total		1,679
	Inpatient	BMI Werndale	3
	Inpatient Total		3
	Outpatient Follow Up	BMI Werndale	5
	Outpatient Follow Up Total		5
	Outpatient New	BMI Werndale	365
	Outpatient New Total		365
19/20 Total			2,052
20/21	Daycase	BMI Werndale	213
	Daycase Total		213
	Inpatient	BMI Werndale	1
	Inpatient Total		1
	Outpatient New	BMI Werndale	44
Outpatient New Total		44	
20/21 Total			258
21/22	Daycase	BMI Werndale	840
		Community Eye Care	1,358
		Spa Medica	753
	Daycase Total		2,951
	Outpatient Follow Up	Community Eye Care	170
		Spa Medica	32
	Outpatient Follow Up Total		202
	Outpatient New	BMI Werndale	10
		Community Eye Care	1,239
		Spa Medica	919
Outpatient New Total		2,168	
Outpatient Procedure	Community Eye Care	5	
	Spa Medica	330	
Outpatient Procedure Total		335	
21/22 Total			5,656
22/23	Daycase	CHEC	746
		Spa Medica	408
	Daycase Total		1,154
	Outpatient Follow Up	CHEC	715
		Spa Medica	365
	Outpatient Follow Up Total		1,080
	Pre-Assessment	CHEC	446
Spa Medica		24	
Pre-Assessment Total		470	
22/23 Total			2,704
Grand Total			12,859

Ophthalmology Incident Data Review

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Background

As per the approved Clinical Services Plan methodology, Complaints reported between 1 August 2018 and 31st July 2023 have been included for Ophthalmology Services at Amman Valley Hospital, North Road Eye Clinic, Bronglais Hospital, Withybush Hospital, Glangwili Hospital and Prince Philip Hospital. Although Cardigan Integrated Care Centre, Aberaeron Hospital and South Pembrokeshire Hospital are included within the scope of the overall issues paper, no incidents data exists for these sites.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for the rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported incidents attributable to Service when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the Service that may be related to other services within the previous system.

Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the Service.

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

Service Changes

The temporary services change in response to COVID commenced April 16, 2020, and is reflected by a vertical blue line. The service changes were ratified during May public board and is shown in the graph by a vertical red line. The summary of the service change is as follows:

- Services including General Surgery, Colorectal, Breast, Urology, Gynaecology and Ophthalmology have been relocated to a local private hospital, providing outpatient and treatment services for their Unscheduled Care (USC) and Urgent patients.
- All outpatient PSA clinics moved to virtual telephone clinics. Patients PSA are being monitored so no build-up of waiting list and rebooked into clinics 3/6 months' time or if there is a problem referred to the consultant.
- Ophthalmology Services have been relocated to Werndale Hospital, to continue to run the Emergency eye care services.
- Virtual review and triage of all emergency cases.
- Orthoptist telephone consultations are also being undertaken

The second service change took place in September 2021 with the delivery of a Glaucoma Service. Hywel Dda UHB has had a backlog in its glaucoma pathway for some years, and as of March 2020, was already a service with a significant demand-capacity mismatch. This has been made worse by the impact of the COVID-19 pandemic.

- Hywel Dda is not meeting the national target of 95% of patients with an 'R1' health risk factor being seen within 125% of intended time to next event in pathway. Hywel Dda's current performance against this target is 40.6%.

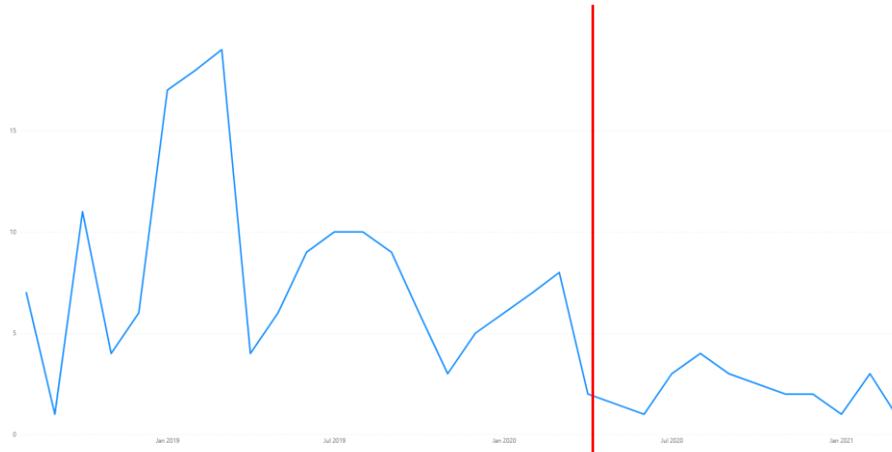
- At this time, 1,300 people each month are not getting the tests they need to stay safe. It is an absolute, non-negotiable requirement for the health boards to put in place, and maintain, services for the identification, diagnosis and management of individuals with glaucoma in the populations they serve.

This is a regional approach, which is reflective of the geographical needs of the population, is supported by clinical and managerial teams working collaboratively across the region and is considered the most appropriate way to deliver the eye care services.

This change is represented by a red line within the charts

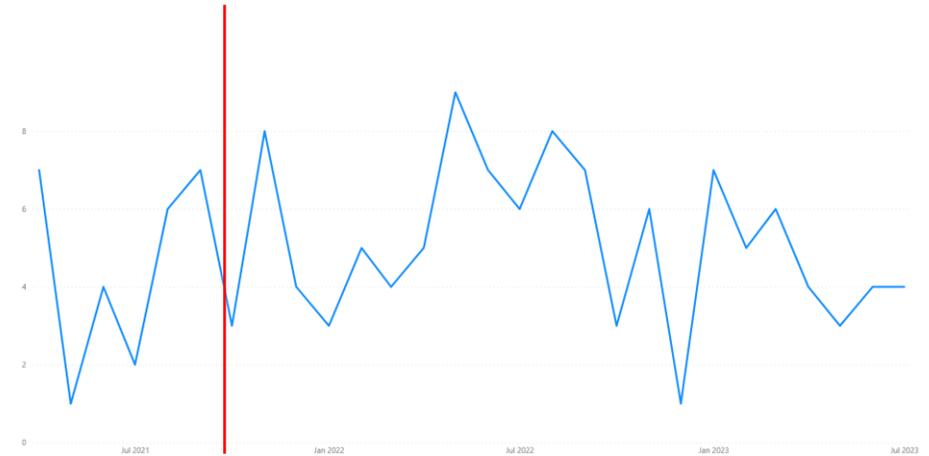
Incidents

All Sites (1st August 2018 – 31st March 2021)



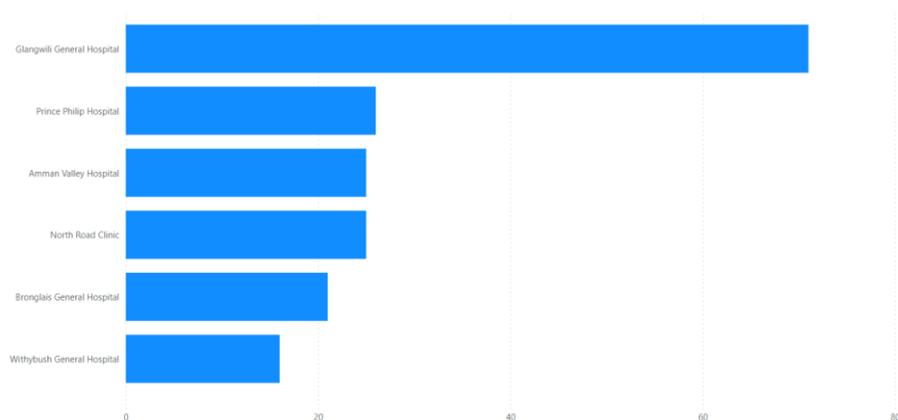
							Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	2018
							7	1	11	4	6	28
Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
17	18	19	4	6	9	10	10	9	6	3	5	116
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
6	7	8	2	0	1	3	4	3	0	2	2	38
Jan 21	Feb 21	Mar 21									2021	
1	3	1									5	
												187

All Sites (1st April 2021 – 31st July 2023)



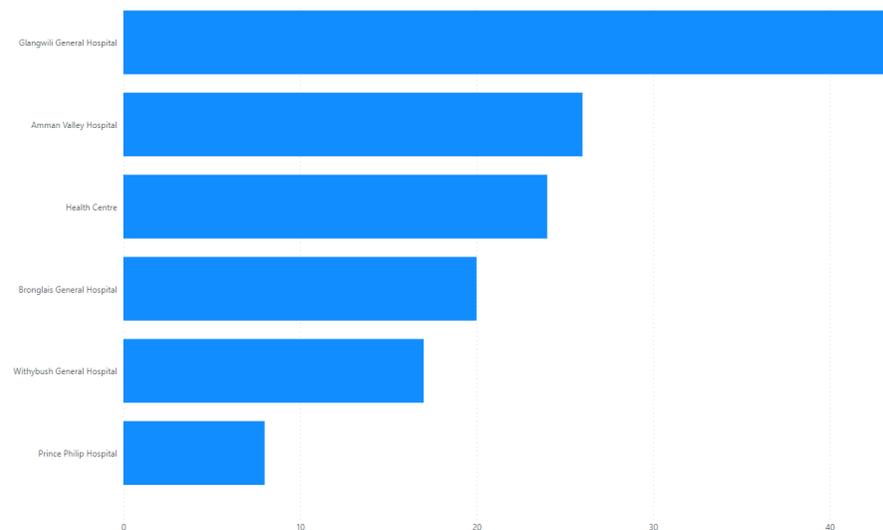
							Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
							7	1	4	2	6	7	3	8	4	42
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022				
3	5	4	5	9	7	6	8	7	3	6	1	59				
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023				
7	5	6	4	3	4	4						33				
												134				

By Location (1st August 2018 – 31st March 2021)



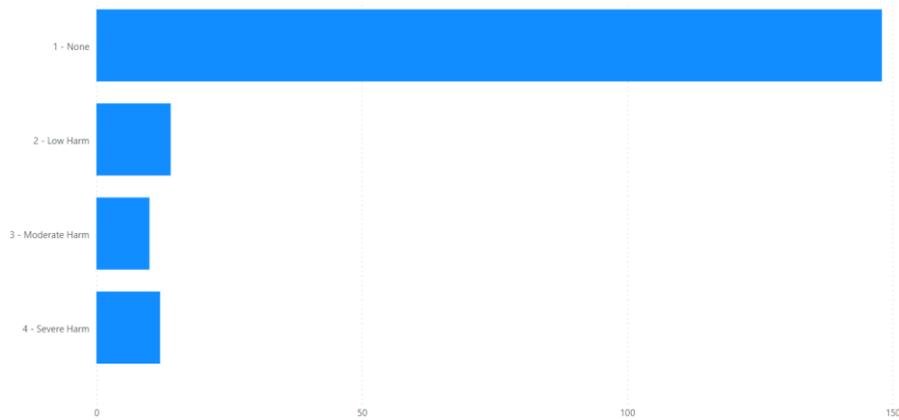
Primary Location	Count
Glangwili General Hospital	71
Prince Philip Hospital	26
Amman Valley Hospital	25
North Road Clinic	25
Bronglais General Hospital	21
Withybush General Hospital	16

By Location (1st April 2021 – 31st July 2023).



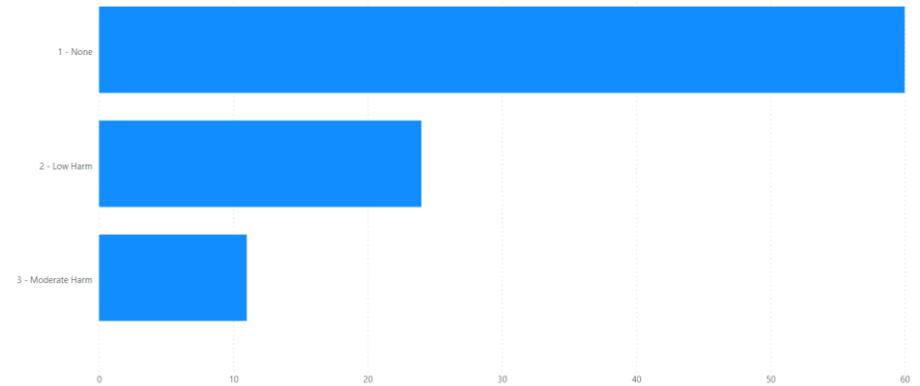
Primary Location	Count
Glangwili General Hospital	44
Amman Valley Hospital	26
Health Centre (North Road Eye Clinic)	24
Bronglais General Hospital	20
Withybush General Hospital	17
Prince Philip Hospital	8

By Severity/Level (1st August 2018 – 31st March 2021)



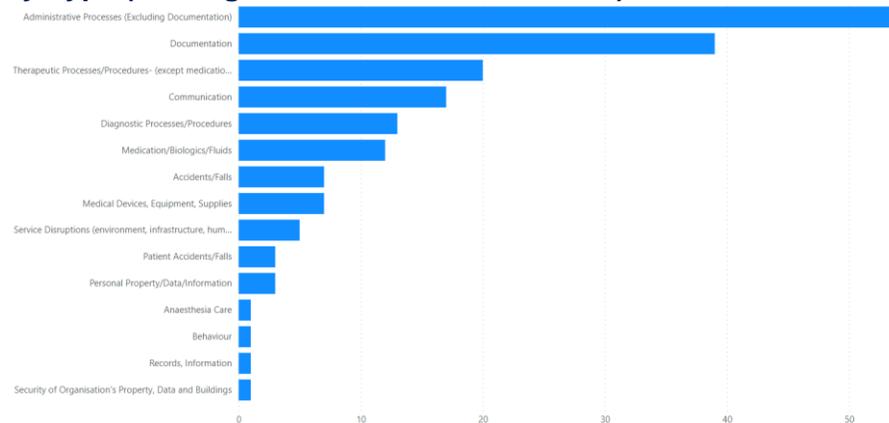
Severity	Count
1 - None	148
2 – Low Harm	14
3 – Moderate Harm	10
4 – Severe Harm	12
5 – Catastrophic Death	0

By Severity/Level (1st April 2021 – 31st July 2023)



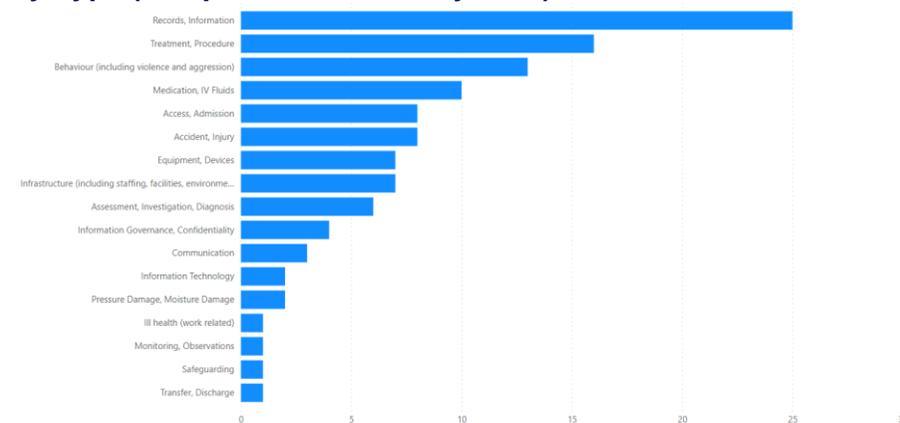
Severity	Count
1 - None	60
2 – Low Harm	24
3 – Moderate Harm	11
4 – Severe Harm	0
5 – Catastrophic Death	0

By Type (1st August 2018 – 31st March 2021)



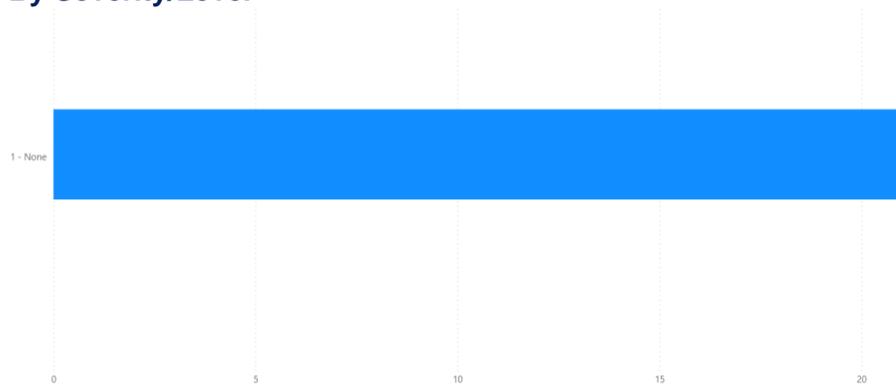
Incident type tier one	Count
Administrative Processes (Excluding documentation)	54
Documentation	39
Therapeutic Processes/Procedures (except medications/fluids/blood/plasma products administration)	20
Communication	17
Diagnostic Processes/Procedures	13
Medication/ Biologics/ Fluids	12
Accidents/ Falls	7
Medical Devices, Equipment, Supplies	7
Service disruptions (environment, infrastructure, human resources)	5
Patient accidents/ Falls	3
Personal Property/ Data/ Information	3
Anaesthesia Care	1
Behaviour	1
Records, information	1
Security of organisations property, data, and buildings	1
Medical Devices, Equipment, Supplies	9
Personal Property/Data/Information	7

By Type (1st April 2021 – 31st July 2023)



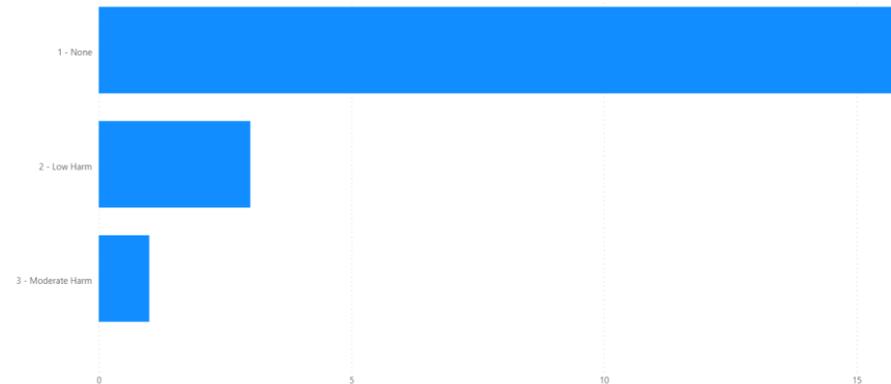
Incident type tier one	Count
Records, information	25
Treatment, procedure	16
Behaviour (including violence and aggression)	13
Medication, IV fluids	10
Access, admission	8
Equipment, devices	7
Infrastructure (including staffing, facilities, environment)	7
Assessment, investigation, diagnosis	6
Information Governance, confidentiality	4
Communication	3
Information Technology	2
Pressure Damage, moisture damage	2
Ill health (work related)	1
Monitoring, observations	1
Safeguarding	1
Transfer, discharge	1

**Bronglais Hospital (1st August 2018 – 31st March 2021)
By Severity/Level**



Severity	Count
1 - None	21
2 – Low Harm	0
3 – Moderate Harm	0
4 – Severe Harm	0
5 – Catastrophic Death	0

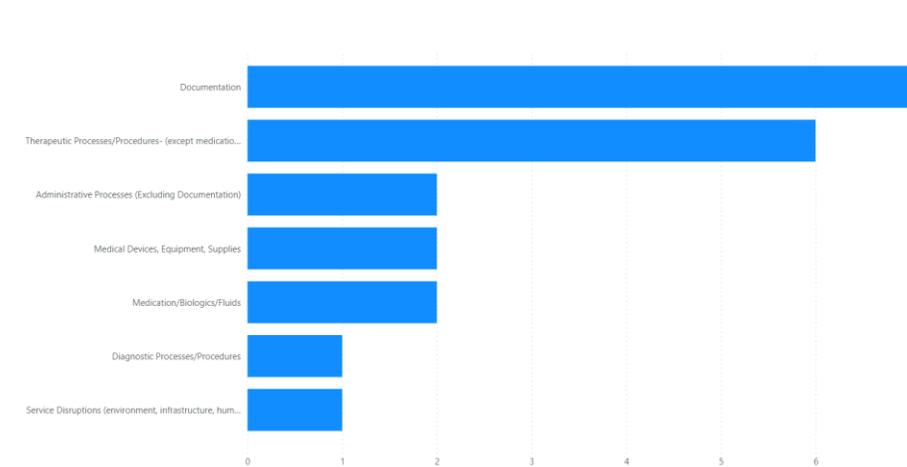
**Bronglais Hospital (1st April 2021 – 31st July 2023)
By Severity/Level**



Severity	Count
1 – None	16
2 – Low Harm	3
3 – Moderate Harm	1
4 – Severe Harm	0
5 – Catastrophic Death	0

Bronglais Hospital (1st August 2018 – 31st March 2021)

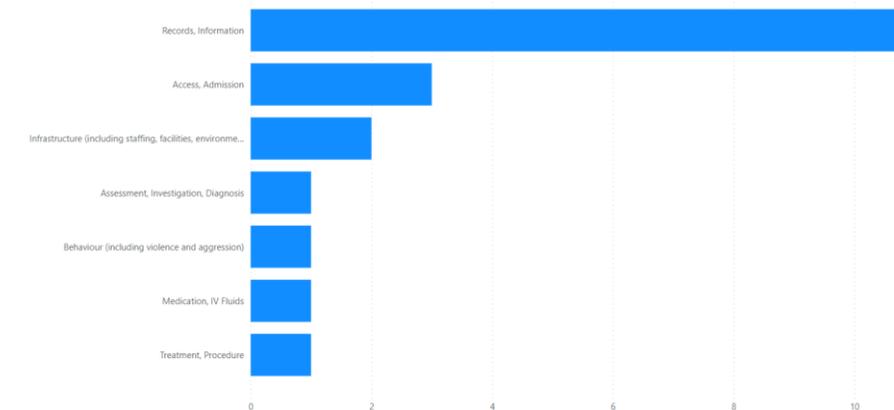
By Type



Incident type tier one	Count
Documentation	7
Therapeutic processes/ Procedures (except medications/fluids/blood/plasma products administration)	6
Administrative processes (excluding documentation)	2
Medical Devices, equipment, supplies	2
Medication/ Biologics/ Fluids	2
Diagnostic processes/ Procedures	1
Service Disruptions (environment, infrastructure, human resources)	1

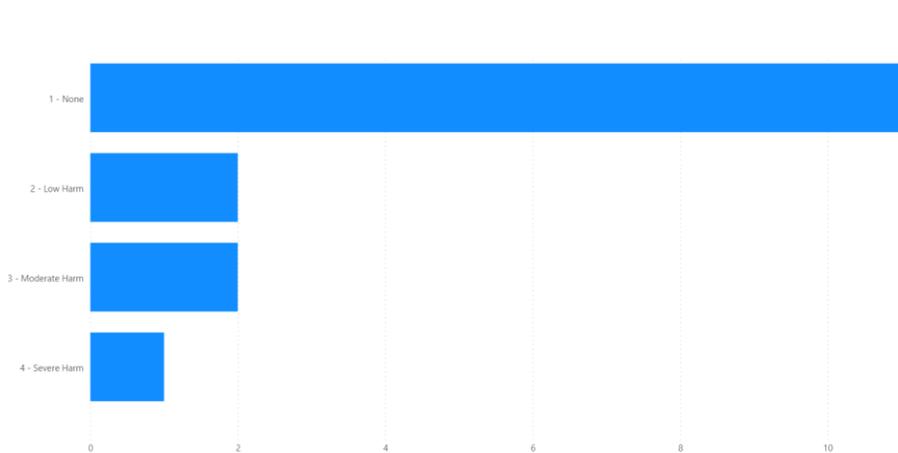
Bronglais Hospital (1st April 2021 – 31st July 2023)

By Type



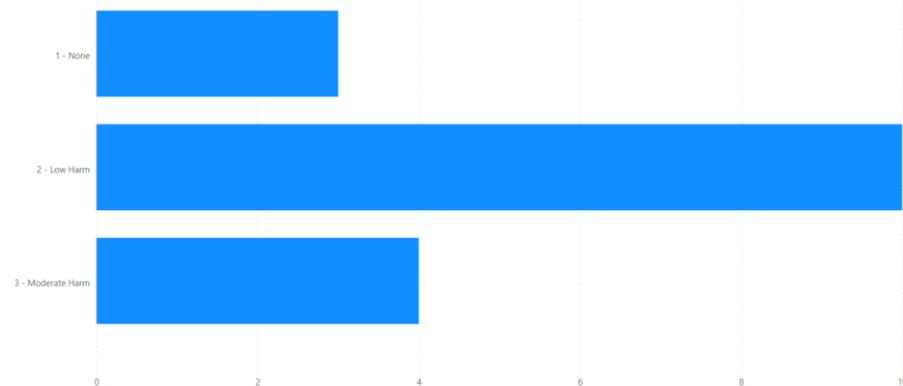
Incident type tier one	Count
Records, information	11
Access, admission	3
Infrastructure (including staffing, facilities, environment)	2
Assessment, investigation, diagnosis	1
Behaviour (including violence and aggression)	1
Medication, IV fluids	1
Treatment, procedure	1

**Withybush Hospital (1st August 2018 – 31st March 2021)
By Severity/Level**



Severity	Count
1 - None	11
2 – Low Harm	2
3 – Moderate Harm	2
4 – Severe Harm	1
5 – Catastrophic Death	0

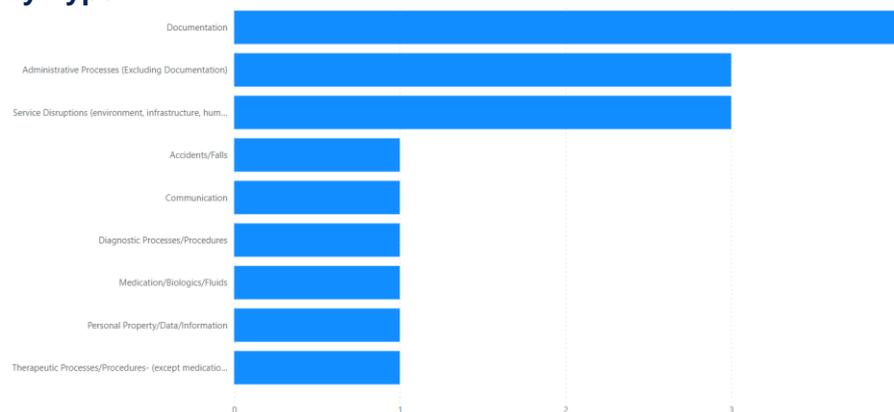
**Withybush Hospital (1st April 2021 – 31st July 2023)
By Severity/Level**



Severity	Count
1 - None	3
2 – Low Harm	10
3 – Moderate Harm	4
4 – Severe Harm	0
5 – Catastrophic Death	0

Withybush Hospital (1st August 2018 – 31st March 2021)

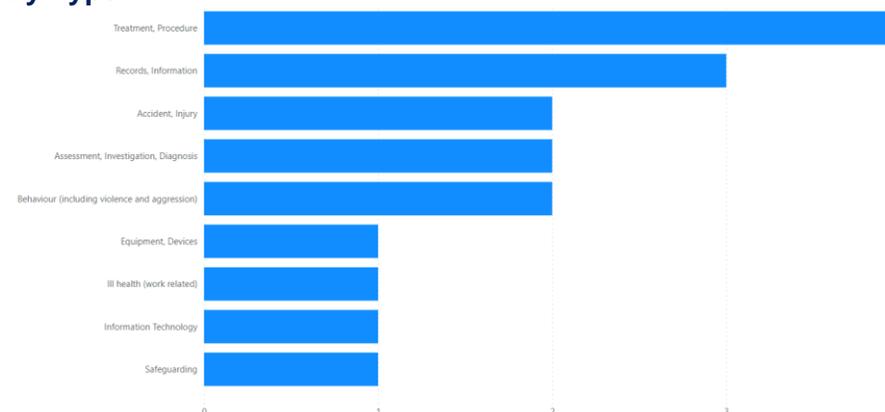
By Type



Incident type tier one	Count
Documentation	4
Administrative Processes (excluding documentation)	3
Service Disruptions (environment, infrastructure, human resources)	3
Accidents/ Falls	1
Communication	1
Diagnostic Processes/ Procedures	1
Medication/ Biologics/ Fluids	1
Personal property/ Data/ Information	1
Therapeutic Processes/Procedures (except medications/fluids/blood/plasma products administration)	1

Withybush Hospital (1st April 2021 – 31st July 2023)

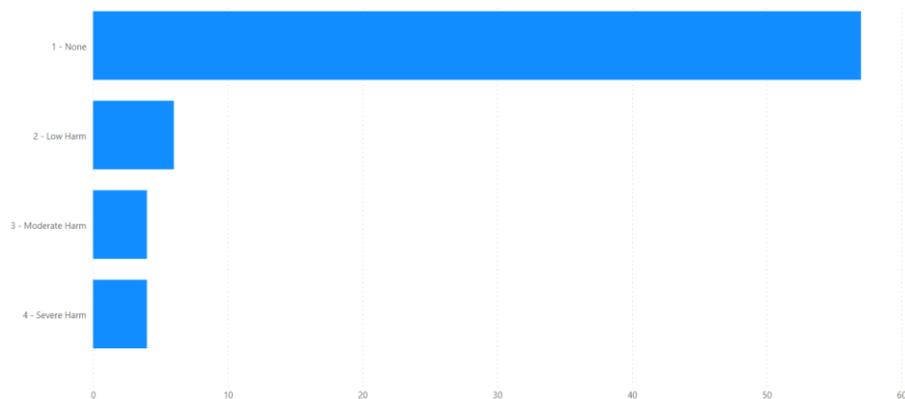
By Type



Incident type tier one	Count
Treatment, procedure	4
Records, information	3
Accident, injury	2
Assessment, investigation, diagnosis	2
Behaviour (including violence and aggression)	2
Equipment, devices	1
Ill health (work related)	1
Information Technology	1
Safeguarding	1

Glangwili Hospital (1st August 2018 – 31st March 2021)

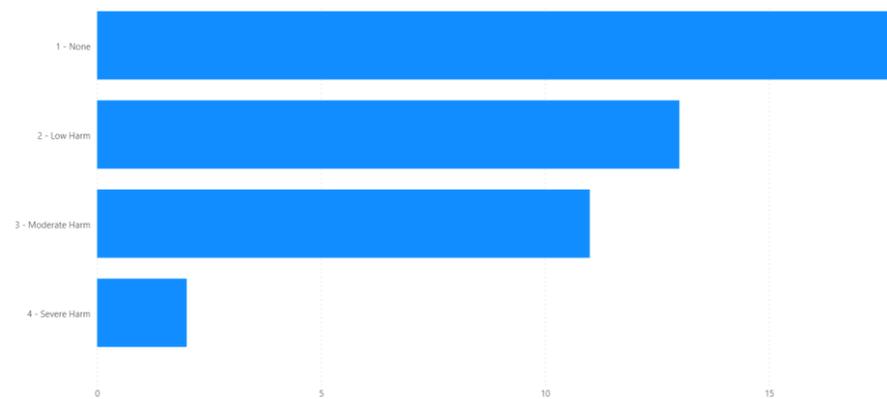
By Severity/Level



Severity	Count
1 - None	57
2 – Low Harm	6
3 – Moderate Harm	4
4 – Severe Harm	4
5 – Catastrophic Death	0

Glangwili Hospital (1st April 2021 – 31st July 2023)

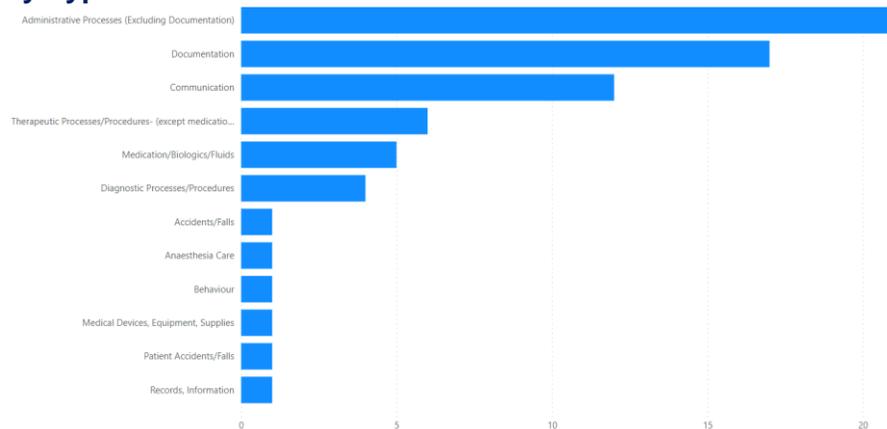
By Severity/Level



Severity	Count
1 - None	18
2 – Low Harm	13
3 – Moderate Harm	11
4 – Severe Harm	2
5 – Catastrophic Death	0

Glangwili Hospital (1st August 2018 – 31st March 2021)

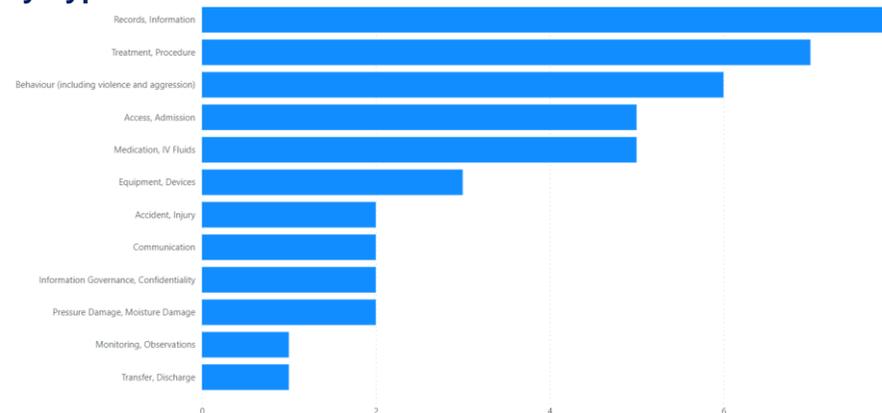
By Type



Incident type tier one	Count
Administrative processes (excluding documentation)	21
Documentation	17
Communication	12
Therapeutic processes/ Procedures (except medications/fluids/blood/plasma products administration)	6
Medication/ Biologics/ Fluids	5
Diagnostic processes/ Procedures	4
Accidents/ Falls	1
Anaesthesia Care	1
Behaviour	1
Medical Devices, equipment, supplies	1
Patient accidents/ Falls	1
Records, information	1

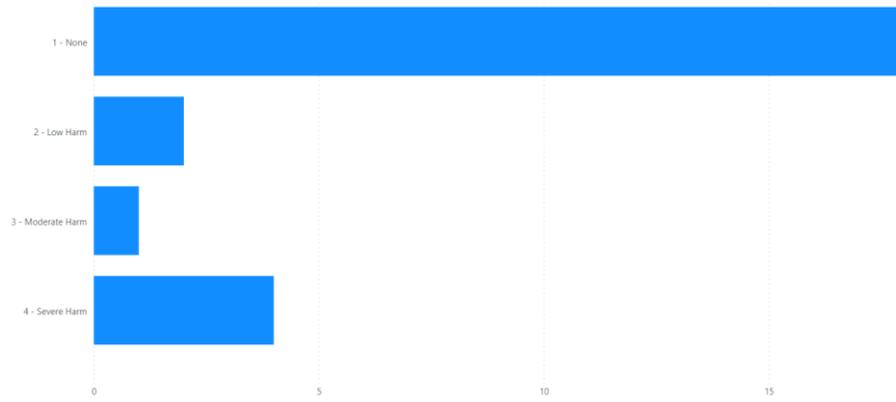
Glangwili Hospital (1st April 2021 – 31st July 2023)

By Type



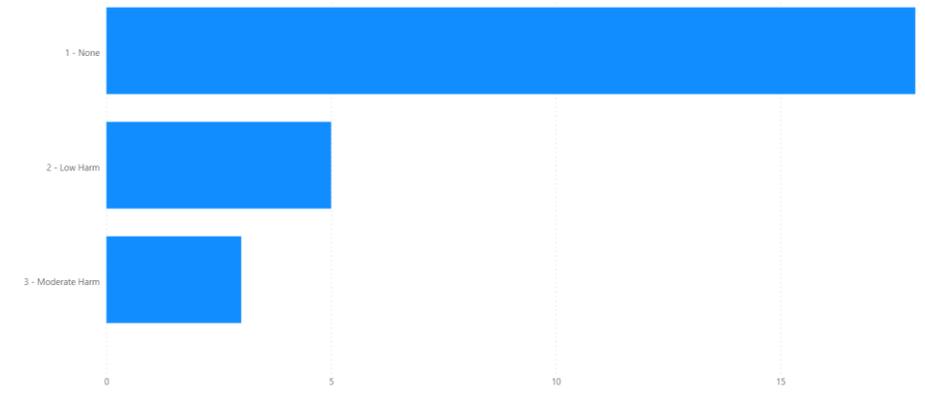
Incident type tier one	Count
Records, Information	8
Treatment, procedure	7
Behaviour (including violence and aggression)	6
Access, admission	5
Medication, IV fluids	5
Equipment, Devices	3
Accident, injury	2
Communication	2
Information Governance, confidentiality	2
Pressure Damage, Moisture Damage	2
Monitoring, observations	1
Transfer, discharge	1

**Amman Valley Hospital (1st August 2018 – 31st March 2021)
By Severity/Level**



Severity	Count
1 - None	18
2 – Low Harm	2
3 – Moderate Harm	1
4 – Severe Harm	4
5 – Catastrophic Death	0

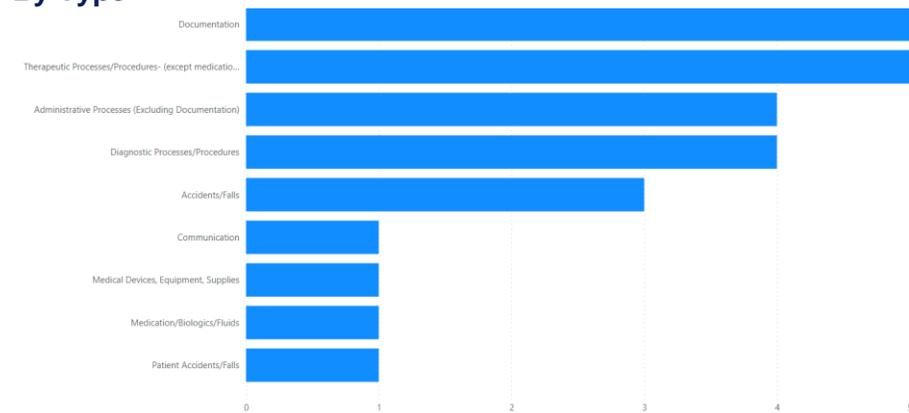
**Amman Valley Hospital (1st April 2021 – 31st July 2023)
By Severity/Level**



Severity	Count
1 – None	18
2 – Low Harm	5
3 – Moderate Harm	3
4 – Severe Harm	0
5 – Catastrophic Death	0

Amman Valley Hospital (1st August 2018 – 31st March 2021)

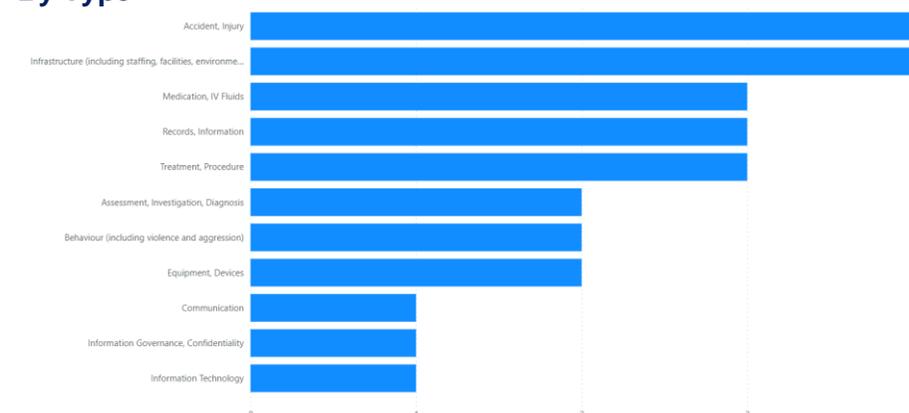
By Type



Incident type tier one	Count
Documentation	5
Therapeutic Processes/ Procedures (except medications/ fluids/ blood/ plasma products administration)	5
Administrative Processes (Excluding Documentation)	4
Diagnostic Processes/ Procedures	4
Accidents/ Falls	3
Communication	1
Medical Devices, Equipment, Supplies	1
Medication/ Biologics/ Fluids	1
Patient accidents/ Falls	1

Amman Valley Hospital (1st April 2021 – 31st July 2023)

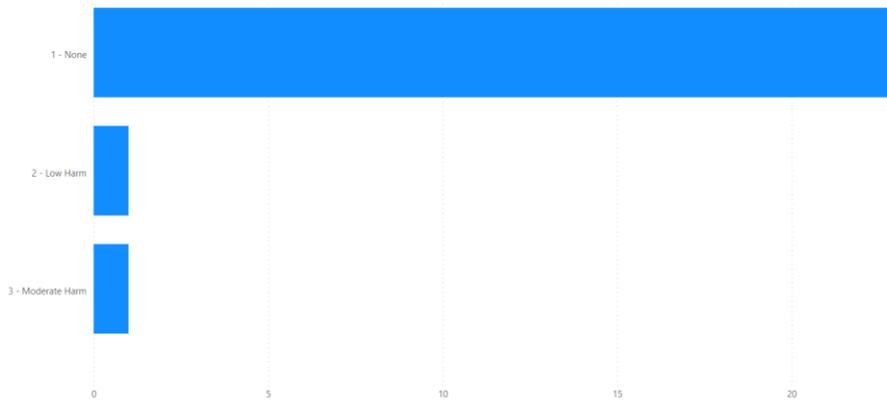
By Type



Incident type tier one	Count
Accident, Injury	4
Infrastructure (including staffing, facilities, environment)	4
Medication, IV fluids	3
Records, Information	3
Treatment, Procedure	3
Assessment, Investigation, Diagnosis	2
Behaviour (including violence and aggression)	2
Equipment, Devices	2
Communication	1
Information Governance, Confidentiality	1
Information Technology	1

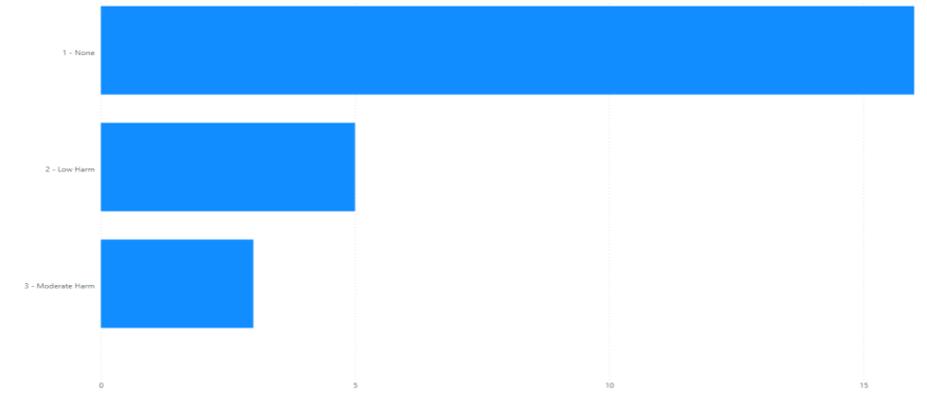
North Road Eye Clinic Hospital (1st August 2018 – 31st March 2021)

By Severity/Level



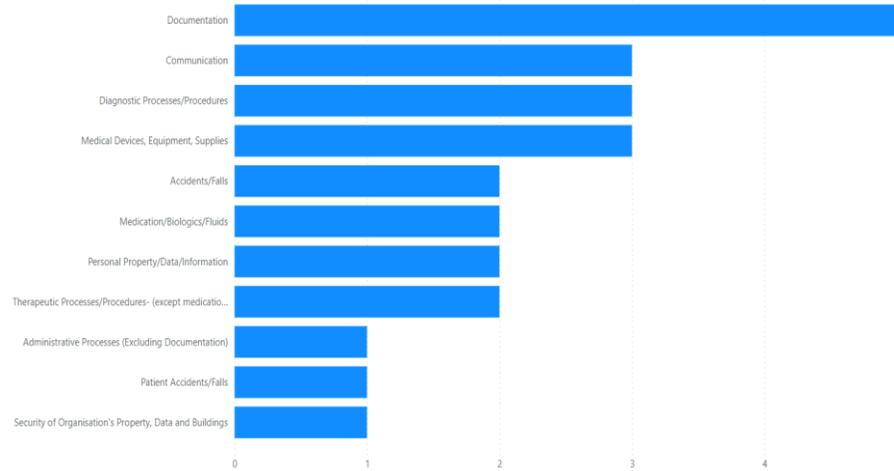
Severity	Count
1 - None	23
2 – Low Harm	1
3 – Moderate Harm	1
4 – Severe Harm	0
5 – Catastrophic Death	0

North Road Eye Clinic Hospital (1st April 2021 – 31st July 2023)
By Severity/Level



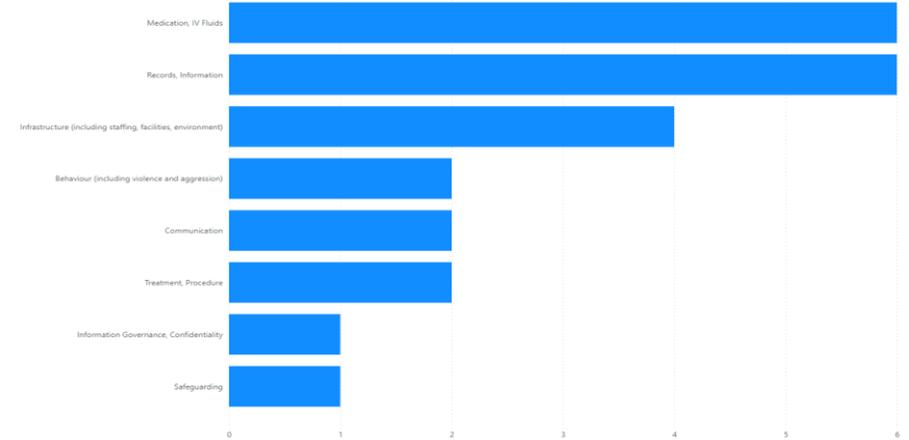
Severity	Count
1 - None	16
2 – Low Harm	5
3 – Moderate Harm	3
4 – Severe Harm	0
5 – Catastrophic Death	0

North Road Eye Clinic (1st August 2018 – 31st March 2021) By Type



Incident type tier one	Count
Documentation	5
Communication	3
Diagnostic Processes/ Procedures	3
Medical; Devices, Equipment, Supplies	3
Accidents/ Falls	2
Medication/ Biologics/ Fluids	2
Personal Property/ Data/ Information	2
Therapeutic Processes/ Procedures – except medications/ fluids/ blood/ plasma products administration)	2
Administrative processes (excluding documentation)	1
Patient accidents/ Falls	1
Security of organisations property, data and buildings	1

North Road Eye Clinic Hospital (1st April 2021 – 31st July 2023) By Type



Incident type tier one	Count
Medication, IV Fluids	6
Records, Information	6
Infrastructure (Including staffing, facilities, environment)	4
Behaviour (including violence and aggression)	2
Communication	2
Treatment, Procedure	2
Information Governance, Confidentiality	1
Safeguarding	1

Ophthalmology Complaints Data Review

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By Type	17
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By Grading	18
Prince Philip Hospital (1st April 2021 – 31st July 2023)	18
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By Type	19
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By Type	19

Background

As per the approved Clinical Services Plan methodology, Complaints reported between 1 August 2018 and 31st July 2023 have been included for Ophthalmology Services at Amman Valley Hospital, North Road Eye Clinic, Bronglais Hospital, Withybush Hospital, Glangwili Hospital and Prince Philip Hospital. Although Cardigan Integrated Care Centre, Aberaeron Hospital and South Pembrokeshire Hospital are included within the scope of the overall issues paper, no complaints data exists for these sites.

Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for the rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported complaints attributable to Service when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the Service that may be related to other services within the previous system.

Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the Service.

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

Service Changes

The temporary services change in response to COVID commenced April 16, 2020, and is reflected by a vertical blue line. The service changes were ratified during May public board and is shown in the graph by a vertical red line. The summary of the service change is as follows:

- Services including General Surgery, Colorectal, Breast, Urology, Gynaecology and Ophthalmology have been relocated to a local private hospital, providing outpatient and treatment services for their Unscheduled Care (USC) and Urgent patients.
- All outpatient PSA clinics moved to virtual telephone clinics. Patients PSA are being monitored so no build-up of waiting list and rebooked into clinics 3/6 months' time or if there is a problem referred to the consultant.
- Ophthalmology Services have been relocated to Werndale Hospital, to continue to run the Emergency eye care services.
- Virtual review and triage of all emergency cases.
- Orthoptist telephone consultations are also being undertaken

The second service change took place in September 2021 with the delivery of a Glaucoma Service. Hywel Dda UHB has had a backlog in its glaucoma pathway for some years, and as of March 2020, was already a service with a significant demand-capacity mismatch. This has been made worse by the impact of the COVID-19 pandemic.

- Hywel Dda is not meeting the national target of 95% of patients with an 'R1' health risk factor being seen within 125% of intended time to next event in pathway. Hywel Dda's current performance against this target is 40.6%.

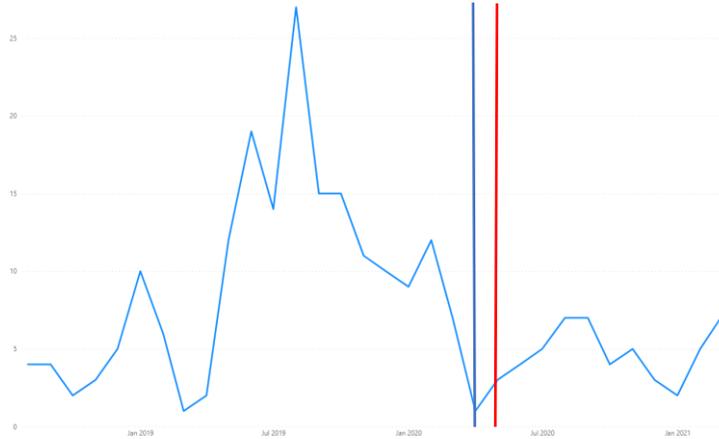
- At this time, 1,300 people each month are not getting the tests they need to stay safe. It is an absolute, non-negotiable requirement for the health boards to put in place, and maintain, services for the identification, diagnosis and management of individuals with glaucoma in the populations they serve.

This is a regional approach, which is reflective of the geographical needs of the population, is supported by clinical and managerial teams working collaboratively across the region and is considered the most appropriate way to deliver the eye care services.

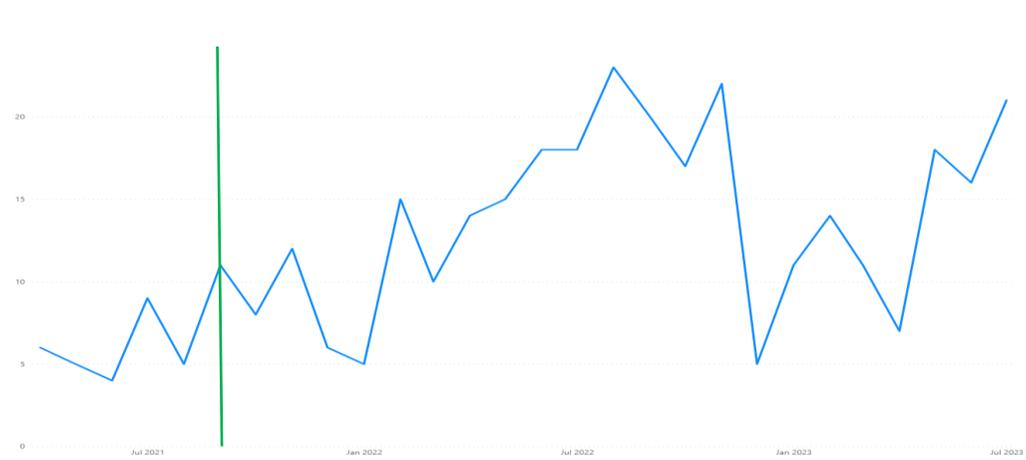
This change is represented by a red line within the charts

Complaints

All sites (1st August 2018 – 31st March 2021)



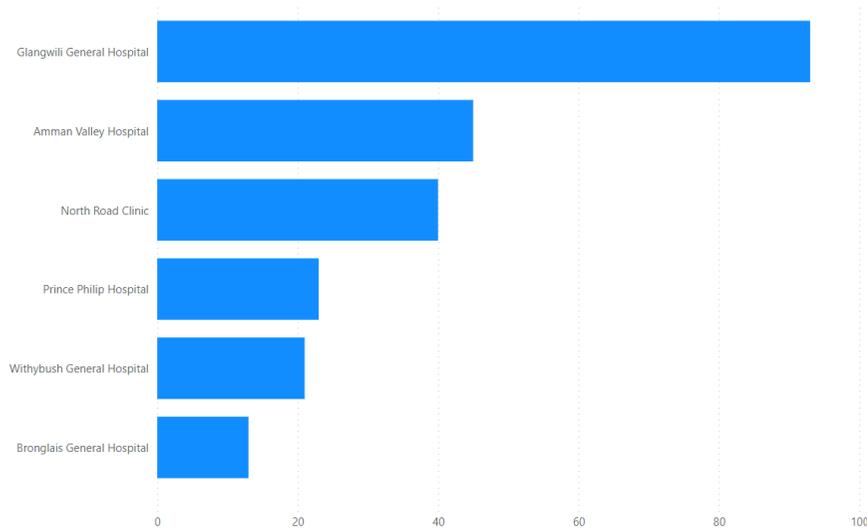
All sites (1st April 2021 – 31st July 2023)



	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	2018						
	4	4	2	3	5	18						
Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
10	6	1	2	12	19	14	27	15	15	11	10	142
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
9	12	7	1	3	4	5	7	7	4	5	3	67
Jan 21	Feb 21	Mar 21										2021
2	5	7										32
												248

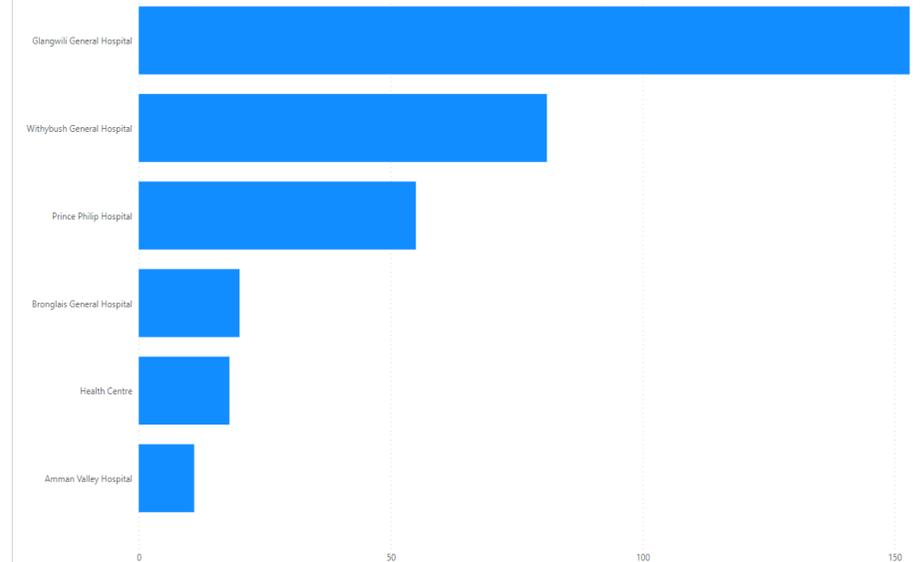
	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021		
	6	5	4	9	5	11	8	12	6	66		
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
5	15	10	14	10	18	18	23	20	17	22	5	157
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
11	14	11	7	18	16	21						98
											321	

By Location (1st August 2018 – 31st March 2021)



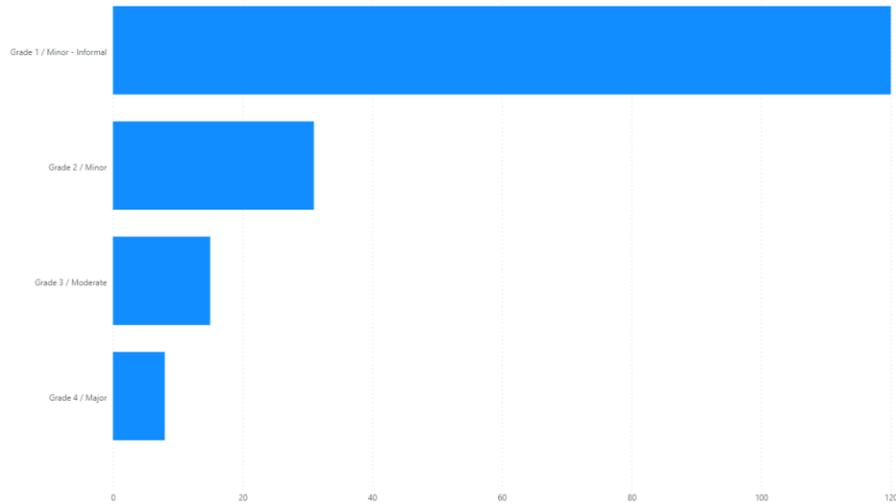
Primary Location	Count
Glangwili General Hospital	93
Amman Valley Hospital	45
North Road Clinic	40
Prince Philip Hospital	23
Withybush General Hospital	21
Bronglais General Hospital	13

By Location (1st April 2021 – 31st July 2023)



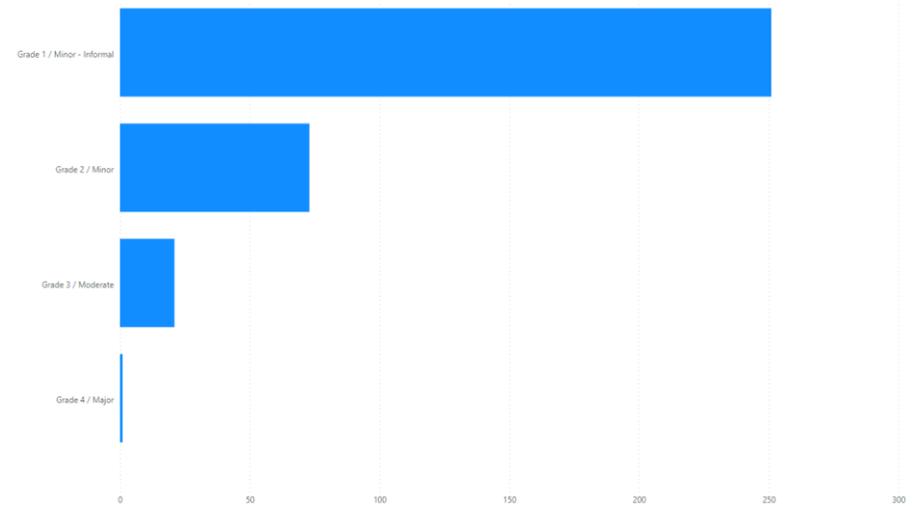
Primary Location	Count
Glangwili General Hospital	153
Withybush General Hospital	81
Prince Philip Hospital	55
Bronglais General Hospital	20
Cardigan Integrated Health Centre	18
North Road Clinic	15
Amman Valley Hospital	11

By Grading (1st August 2018 – 31st March 2021)



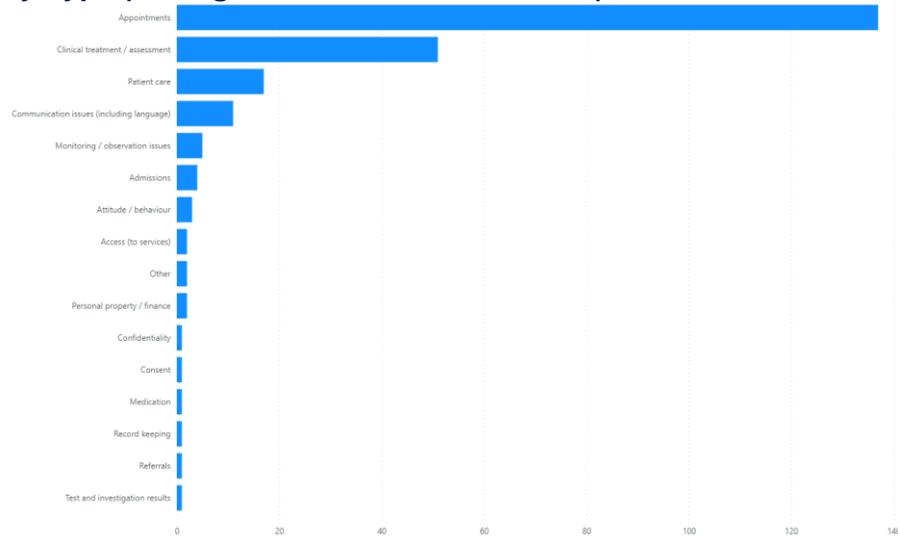
Grade	Count
Grade 1 – Minor - Informal	120
Grade 2 - Minor	31
Grade 3 - Moderate	15
Grade 4 - Major	8
Grade 5 – Catastrophic	0

By Grading (1st April 2021 – 31st July 2023)

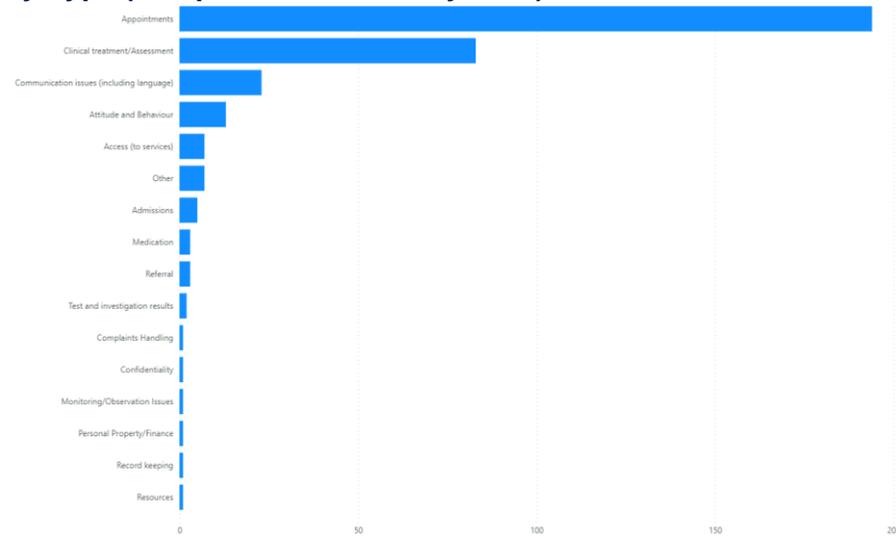


Grade	Count
Grade 1 – Minor - Informal	251
Grade 2 - Minor	73
Grade 3 - Moderate	21
Grade 4 - Major	1
Grade 5 – Catastrophic	0

By Type (1st August 2018 – 31st March 2021)



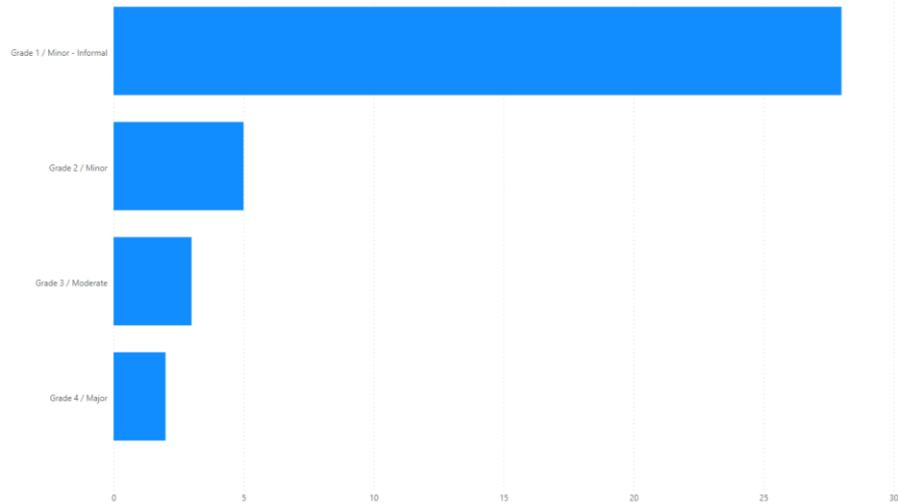
By Type (1st April 2021 – 31st July 2023)



Subject (primary)	Count
Appointments	137
Clinical treatment / assessment	51
Patient Care	17
Communication issues (including language)	11
Monitoring / observation issues	5
Admissions	4
Attitude/ behaviour	3
Access (to services)	2
Other	2
Personal property/ finance	2
Confidentiality	1
Consent	1
Medication	1
Record keeping	1
Referrals	1
Test and investigation results	1

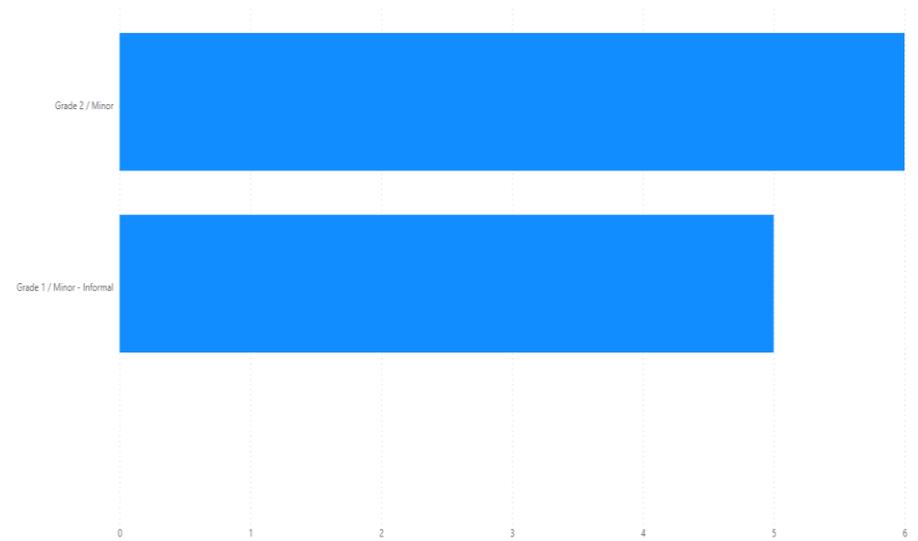
Subject (primary)	Count
Appointments	194
Clinical treatment/Assessment	83
Communication issues (including language)	23
Attitude and Behaviour	13
Access (to services)	7
Other	7
Admissions	5
Medication	3
Referral	3
Test and investigation results	2
Complaints handling	1
Confidentiality	1
Monitoring/ observation issues	1
Personal property/ finance	1
Record keeping	1
Resources	1

Amman Valley Hospital (1st August 2018 – 31st March 2021) By Grading



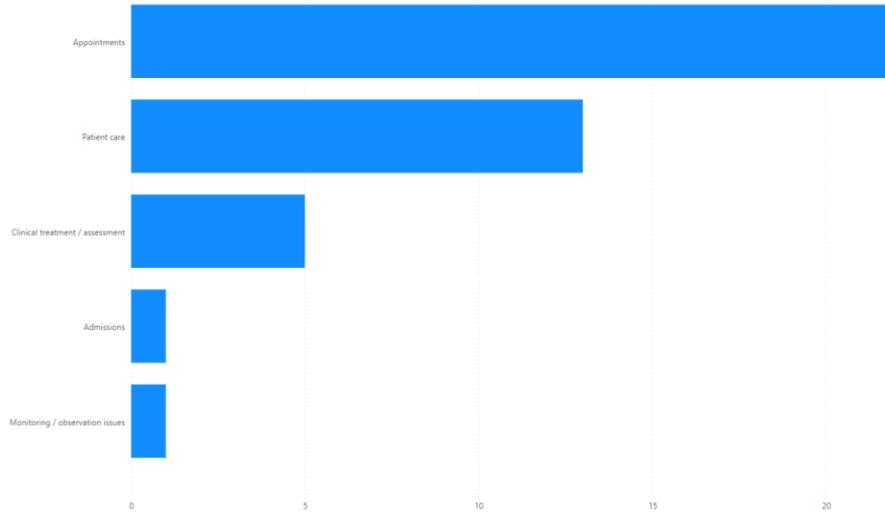
Grade	Count
Grade 1 – Minor, Informal	28
Grade 2 – Minor	5
Grade 3 – Moderate	3
Grade 4 – Major	2
Grade 5 – Catastrophic	0

Amman Valley Hospital (1st April 2021 – 31st July 2023) By Grading



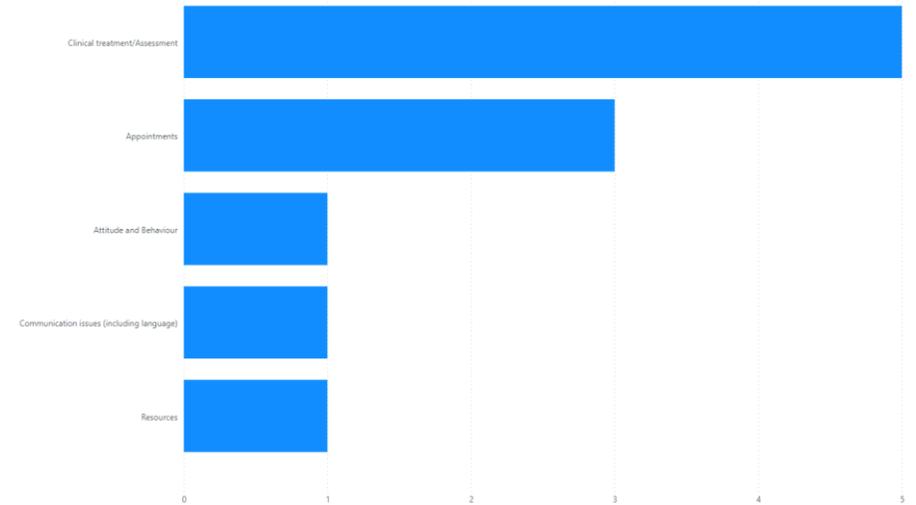
Grade	Count
Grade 2 - Minor	6
Grade 1 – Minor, Informal	5
Grade 3 – Moderate	0
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Amman Valley Hospital (1st August 2018 – 31st March 2021) By Type



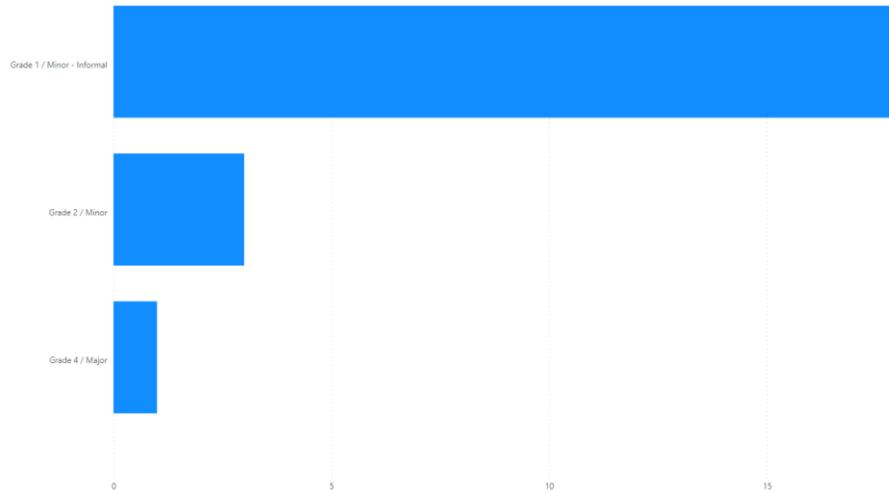
Subject (primary)	Count
Appointments	22
Patient Care	13
Clinical treatment / assessment	5
Admissions	1
Monitoring / observation issues	1

Amman Valley Hospital (1st April 2021 – 31st July 2023) By Type



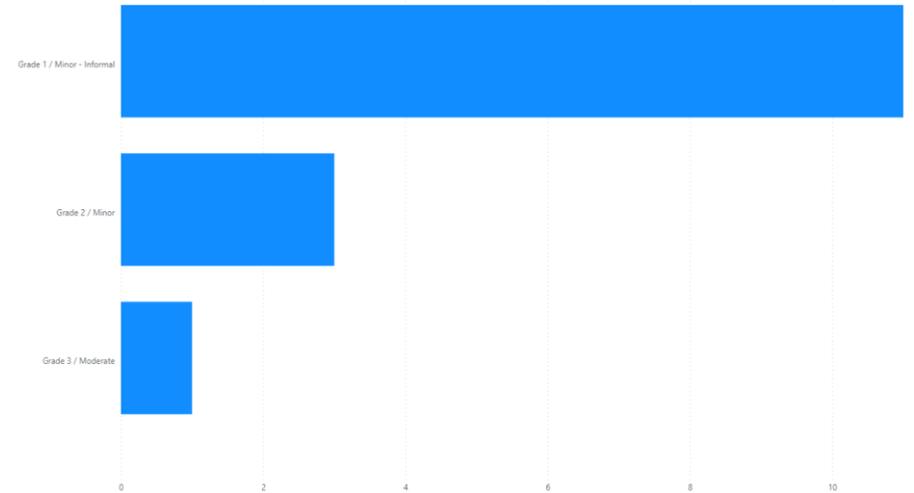
Subject (primary)	Count
Clinical treatment/ assessment	5
Appointments	3
Attitude and Behaviour	1
Communication issues (including language)	1
Resources	1

**North Road Eye Clinic (1st August 2018 – 31st March 2021)
By Grading**



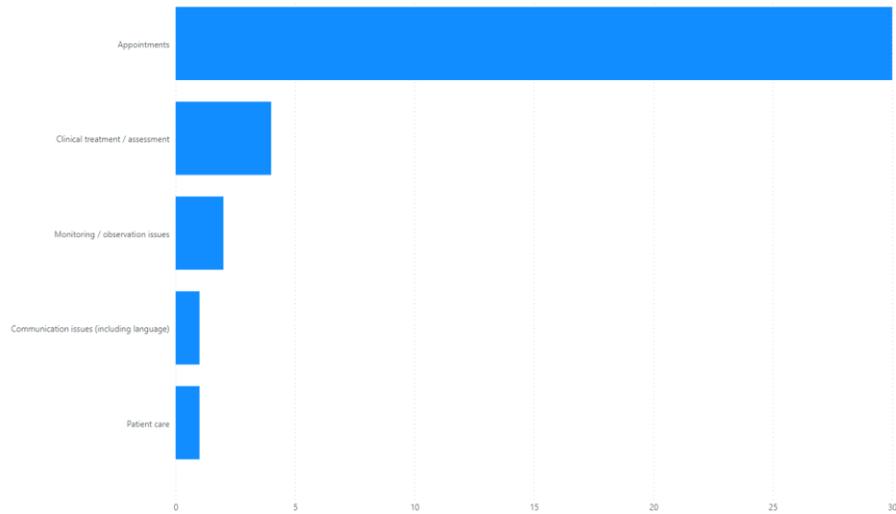
Grade	Count
Grade 1 – Minor, Informal	18
Grade 2 – Minor	3
Grade 4 – Major	1
Grade 3 – Moderate	0
Grade 5 – Catastrophic	0

**North Road Eye Clinic (1st April 2021 – 31st July 2023)
By Grading**



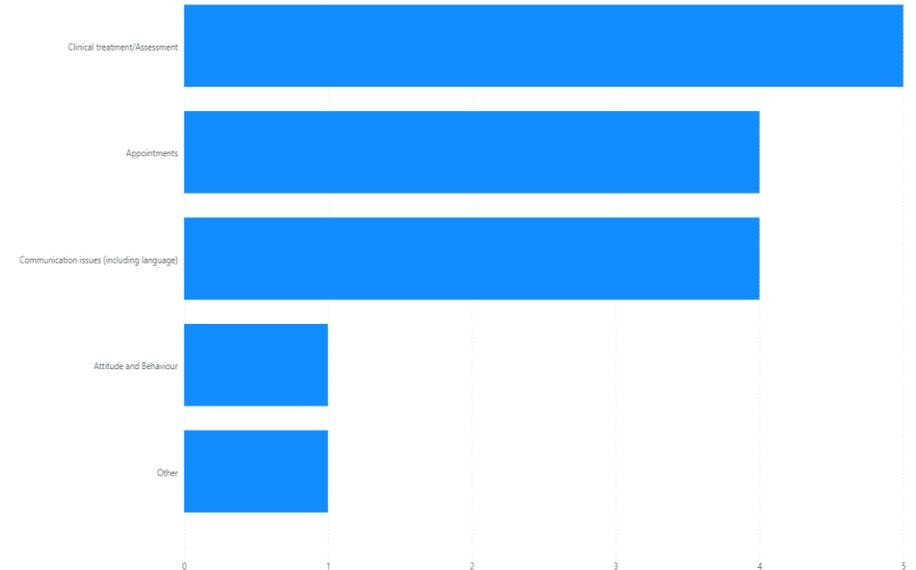
Grade	Count
Grade 1 – Minor, Informal	11
Grade 2 – Minor	3
Grade 3 – Moderate	1
Grade 4 – Major	0
Grade 5 – Catastrophic	0

**North Road Eye Clinic (1st August 2018 – 31st March 2021)
By Type**



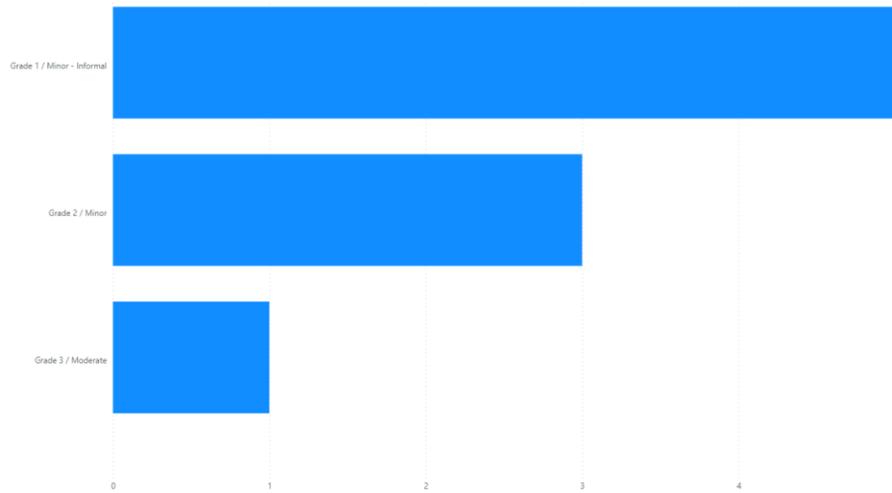
Subject (primary)	Count
Appointments	30
Clinical treatment/Assessment	4
Monitoring / observation issues	2
Communication issues (including language)	1
Patient care	1

**North Road Eye Clinic (1st April 2021 – 31st July 2023)
By Type**



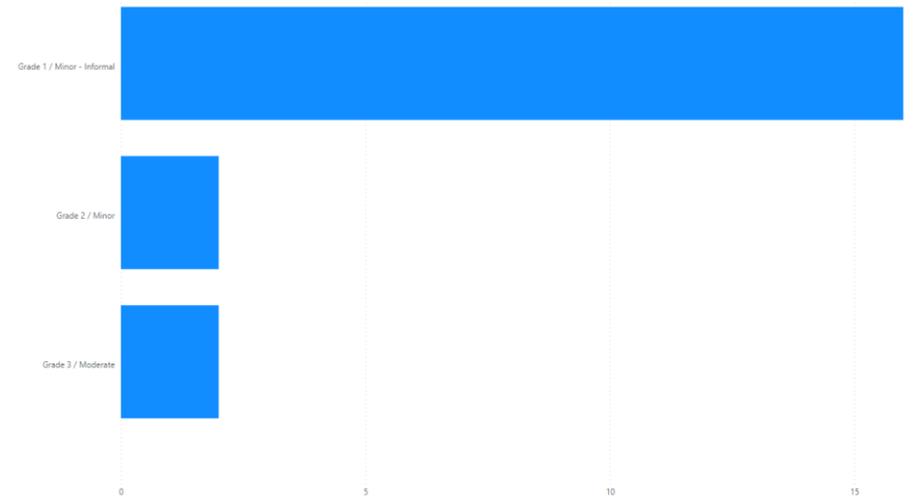
Subject (primary)	Count
Clinical treatment/Assessment	5
Appointments	4
Communication issues (including language)	4
Attitude and behaviour	1
Other	1

**Bronglais Hospital (1st August 2018 – 31st March 2021)
By Grading**



Grade	Count
Grade 1 – Minor - Informal	5
Grade 2 - Minor	3
Grade 3 - Moderate	1
Grade 4 – Major	0
Grade 5 – Catastrophic	0

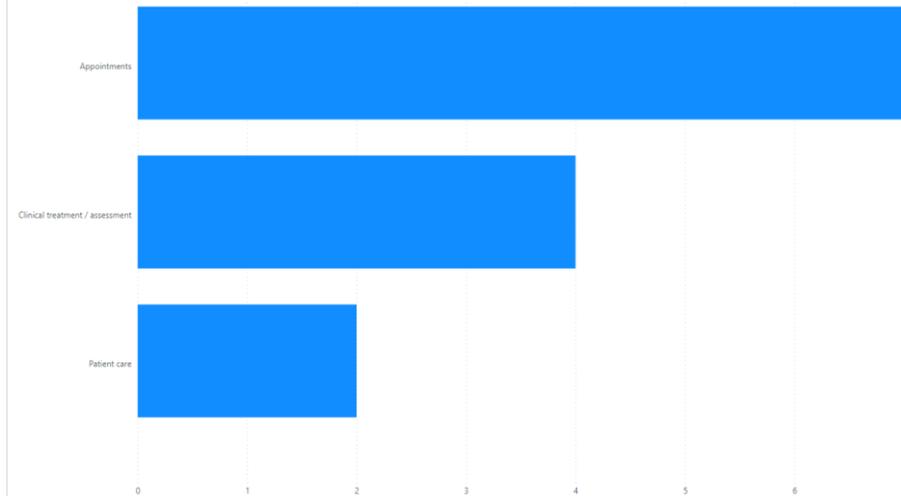
**Bronglais Hospital (1st April 2021 – 31st July 2023)
By Grading**



Grade	Count
Grade 1 – Minor - Informal	16
Grade 2 - Minor	2
Grade 3 - Moderate	2
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Bronglais Hospital (1st August 2018 – 31st March 2021)

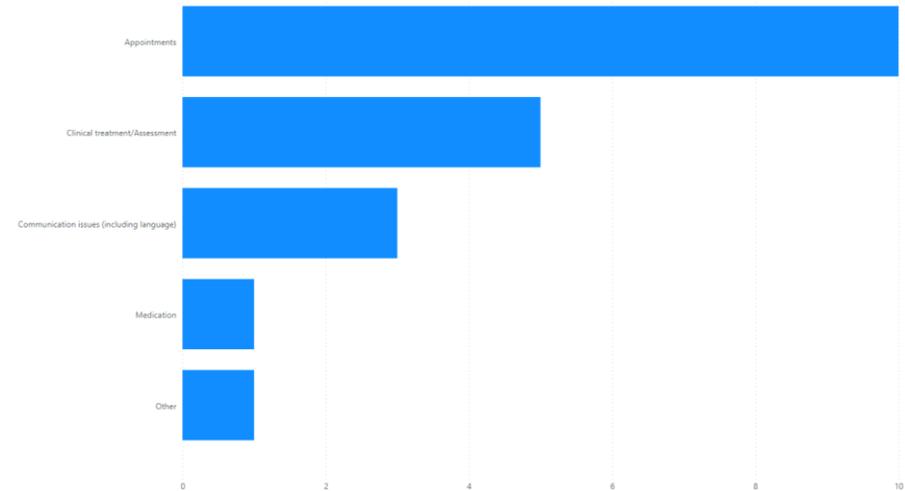
By Type



Subject (primary)	Count
Appointments	7
Clinical treatment/Assessment	4
Patient Care	2

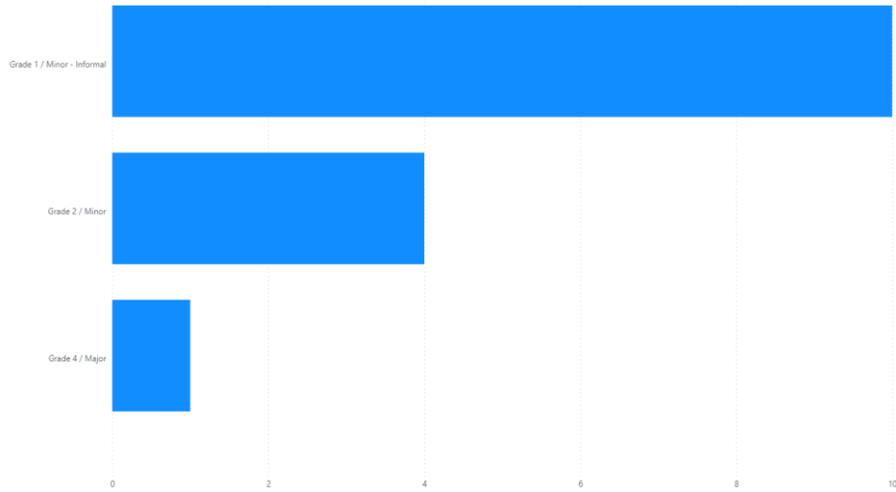
Bronglais Hospital (1st April 2021 – 31st July 2023)

By Type



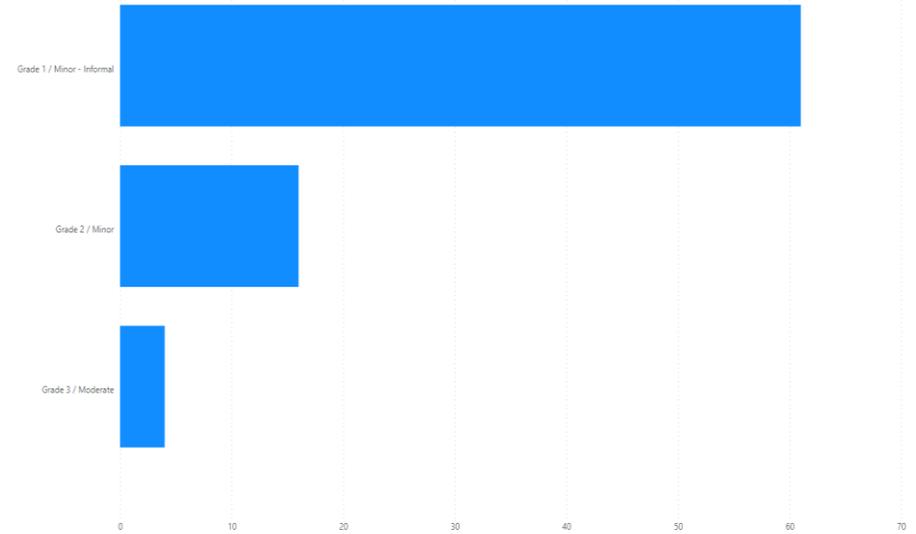
Subject (primary)	Count
Appointments	10
Clinical treatment/Assessment	5
Communication issues (including language)	3
Medication	1
Other	1

**Withybush Hospital (1st August 2018 – 31st March 2021)
By Grading**



Grade	Count
Grade 1 – Minor - Informal	10
Grade 2 - Minor	4
Grade 4 - Major	1
Grade 3 – Moderate	0
Grade 5 - Catastrophic	0

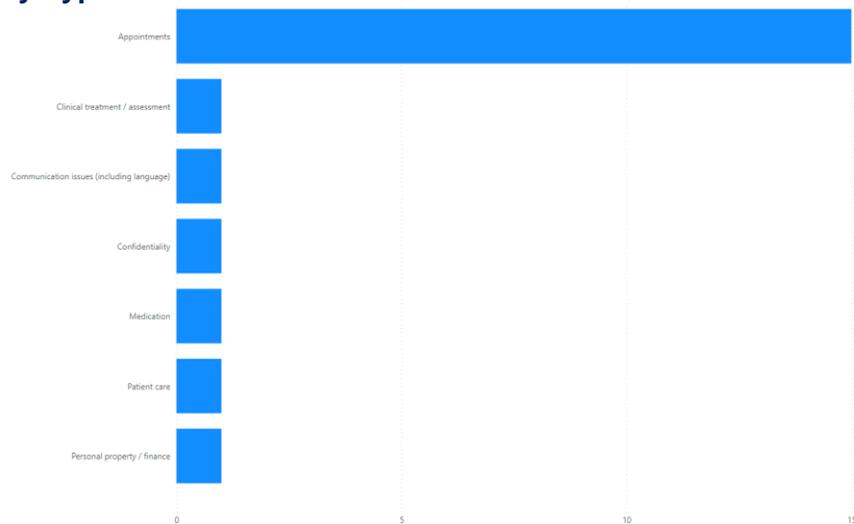
**Withybush Hospital (1st April 2021 – 31st July 2023)
By Grading**



Grade	Count
Grade 1 – Minor - Informal	61
Grade 2 - Minor	16
Grade 3 - Moderate	3
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Withybush Hospital (1st August 2018 – 31st March 2021)

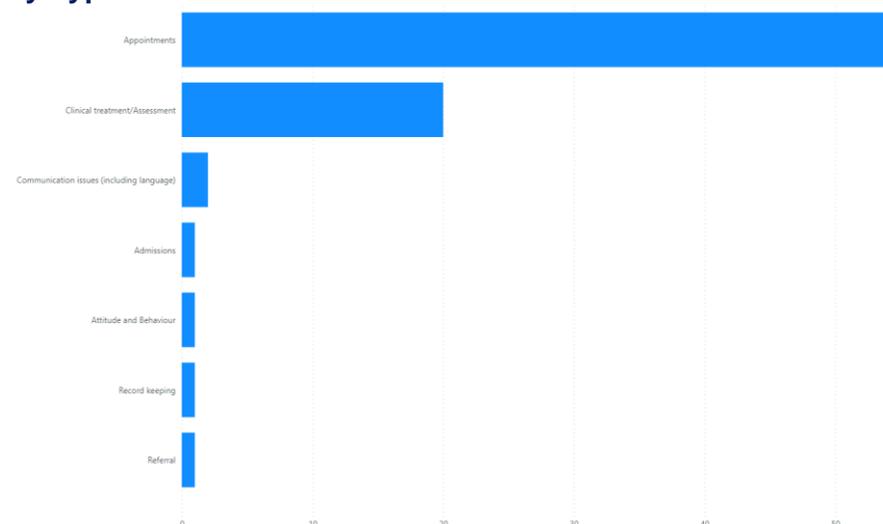
By Type



Subject (primary)	Count
Appointments	15
Clinical treatment/Assessment	1
Communication issues (including language)	1
Confidentiality	1
Medication	1
Patient Care	1
Personal Property/ finance	1

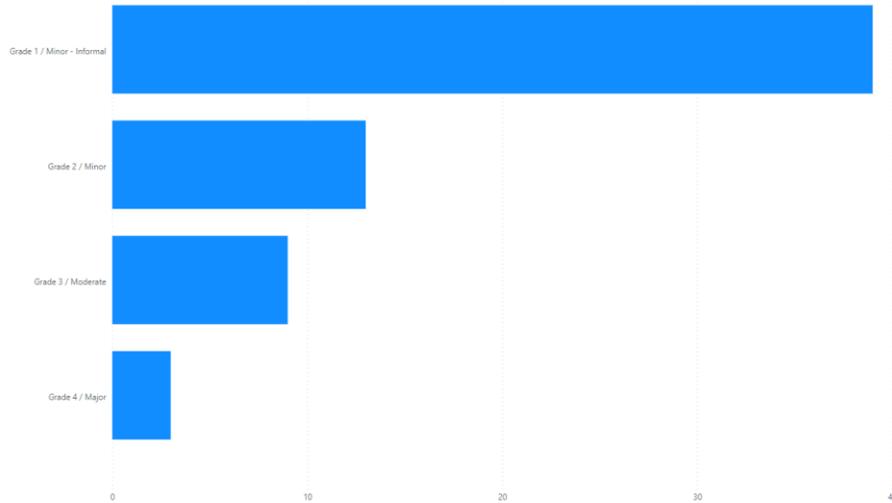
Withybush Hospital (1st April 2021 – 31st July 2023)

By Type



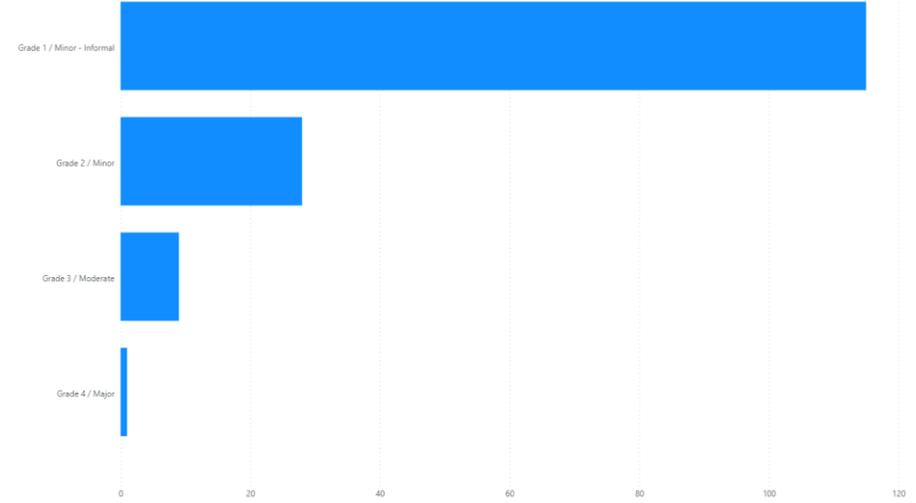
Subject (primary)	Count
Appointments	55
Clinical treatment/Assessment	20
Communication (including language)	2
Admissions	1
Attitude and behaviour	1
Record keeping	1
Referral	1

Glangwili Hospital (1st August 2018 – 31st March 2021)
By Grading



Grade	Count
Grade 1 – Minor - Informal	39
Grade 2 - Minor	13
Grade 3 - Moderate	9
Grade 4 – Major	3
Grade 5 – Catastrophic	0

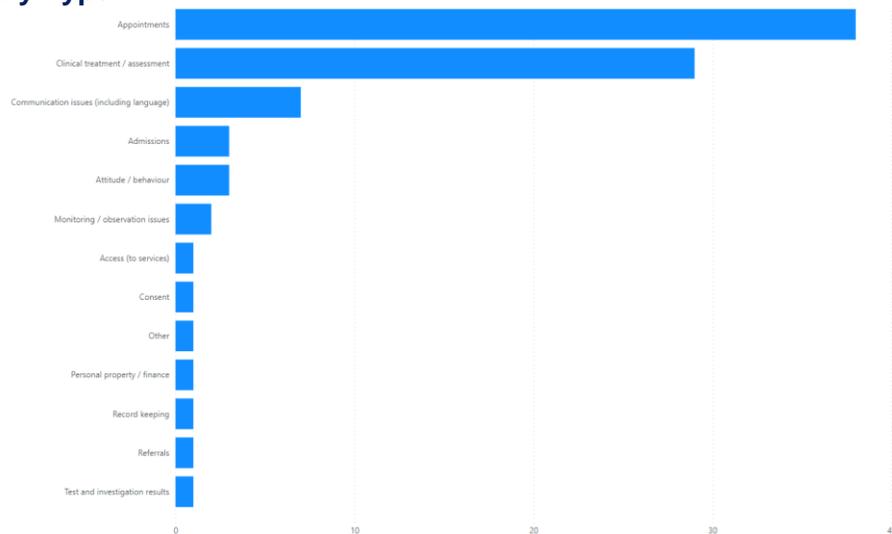
Glangwili Hospital (1st April 2021 – 31st July 2023)
By Grading



Grade	Count
Grade 1 – Minor - Informal	115
Grade 2 - Minor	28
Grade 3 - Moderate	9
Grade 4 - Major	1
Grade 5 – Catastrophic	0

Glangwili Hospital (1st August 2018 – 31st March 2021)

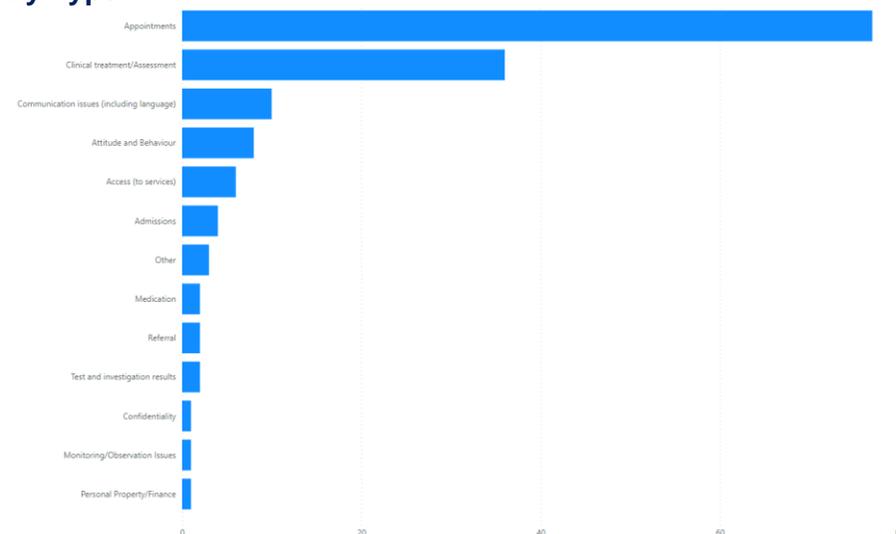
By Type



Subject (primary)	Count
Appointments	38
Clinical treatment/Assessment	29
Communication issues (including language)	7
Admissions	3
Attitude/ behaviour	3
Monitoring/ observation issues	2
Access (to service)	1
Consent	1
Other	1
Personal property/ finance	1
Record keeping	1
Referrals	1
Test and investigation results	1

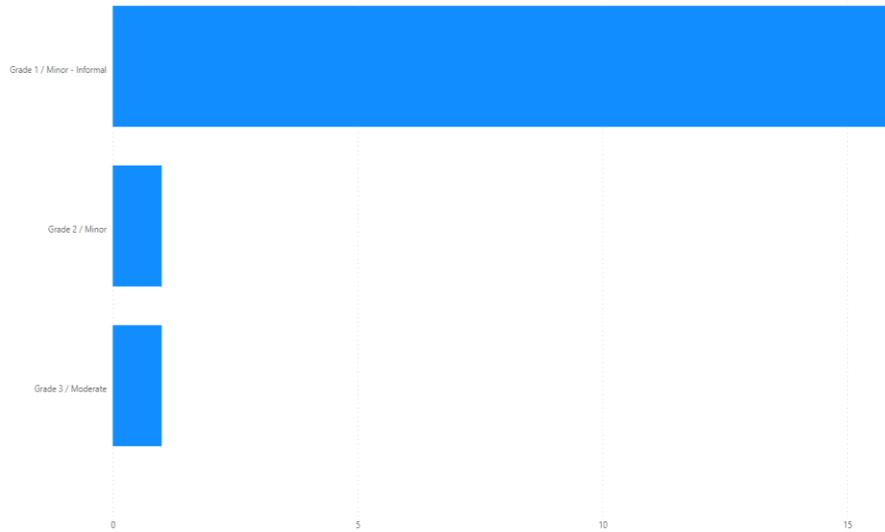
Glangwili Hospital (1st April 2021 – 31st July 2023)

By Type



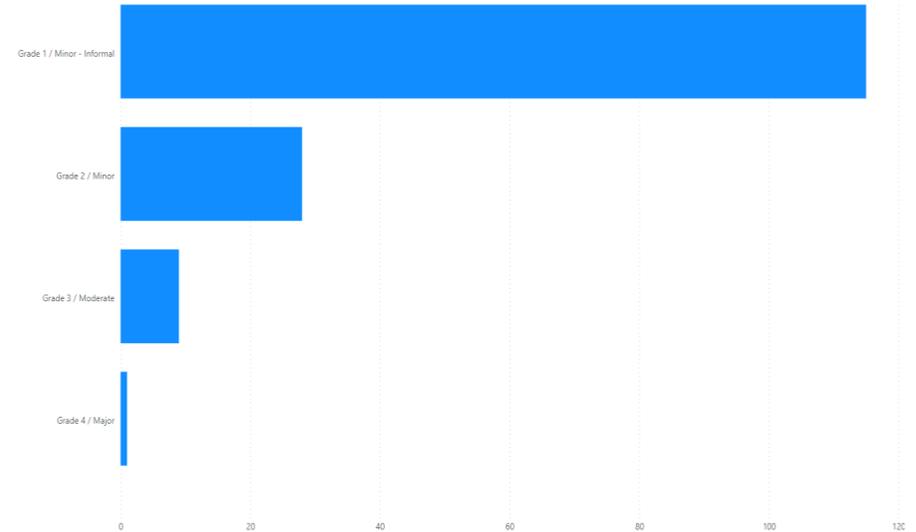
Subject (primary)	Count
Appointments	77
Clinical treatment/Assessment	36
Communication issues (including language)	10
Attitude / behaviour	8
Access (to service)	6
Admissions	4
Other	3
Medication	2
Referral	2
Test and investigation results	2
Confidentiality	1
Monitoring/ observation issues	1
Personal property/ finance	1

**Prince Philip Hospital (1st August 2018 – 31st March 2021)
By Grading**



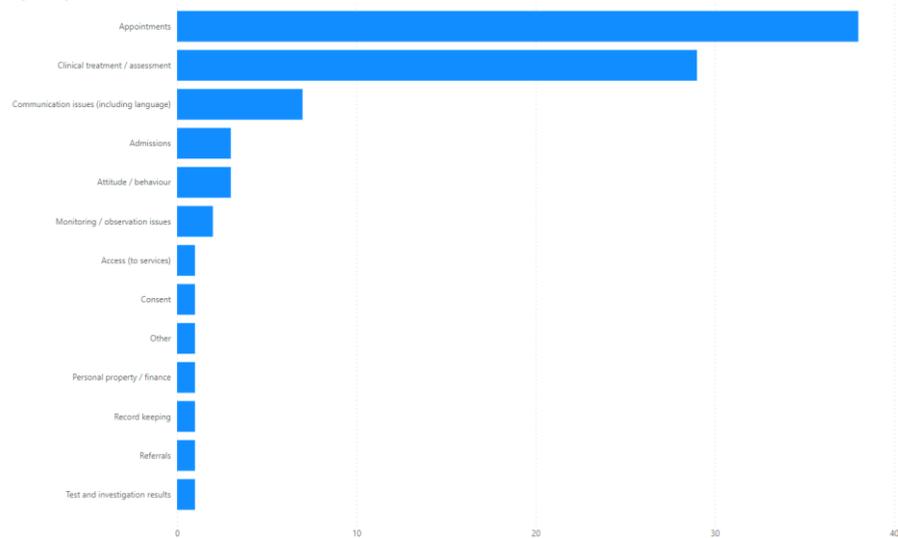
Grade	Count
Grade 1 – Minor - Informal	16
Grade 2 - Minor	1
Grade 3 - Moderate	1
Grade 4 – Major	0
Grade 5 – Catastrophic	0

**Prince Philip Hospital (1st April 2021 – 31st July 2023)
By Grading**



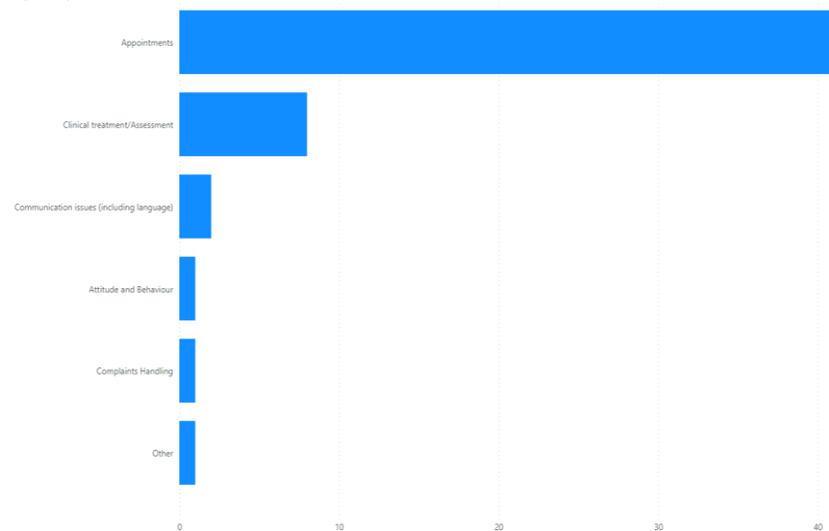
Grade	Count
Grade 1 – Minor - Informal	115
Grade 2 - Minor	28
Grade 3 - Moderate	9
Grade 4 – Major	0
Grade 5 – Catastrophic	0

Prince Philip Hospital (1st August 2018 – 31st March 2021) By Type



Subject (primary)	Count
Appointments	38
Clinical treatment/Assessment	29
Communication issues (including language)	7
Admissions	3
Attitude/ behaviour	3
Monitoring/ observation issues	2
Access (to services)	1
Consent	1
Other	1
Personal property/ finance	1
Record keeping	1
Referrals	1
Test and investigation results	1

Prince Philip Hospital (1st April 2021 – 31st July 2023) By Type



Subject (primary)	Count
Appointments	42
Clinical treatment/Assessment	8
Communication issues (including language)	2
Attitude / behaviour	1
Complaints handling	1
Other	1

Ophthalmology Patient Experience and Compliments Data

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3 Sentiments that relate to Compliment	7
3 Health Board Values that relate to Compliment	7
Themes – 2021	Error! Bookmark not defined.
Themes – 2022	7

Background

As per the approved Clinical Services Plan methodology, Patient Experience data captured has been included for Urology Services at Bronglais Hospital, Withybush Hospital, Glangwili Hospital and Prince Philip Hospital.

Due to data formatting across the current Civica system and historical records, data has only been analysed from 1st April 2021 to 31st July 2023. Historical records, pre-April 2021, cannot be assigned to particular Services in their entirety and so the methodology was updated to only analyse the current Civica system data.

Due to the implementation of the new Civica system, there was an initial decline in patient feedback as the system was being established and rolled out across the Health Board. The new system was implemented on a phased basis and therefore some services had a higher percentage of the feedback in the early stages. There will be an ongoing increase since the introduction of Civica as the Health Board's priority is to increase the volume of feedback.

Traditionally, emergency departments have always had a larger number of claims, complaints and patient feedback due to activity numbers. Patients that have a number of appointments in a relatively short period of time within a Service will generate more feedback.

It is possible that the data shows a variation in the number of reported complaints attributable to a **Service**. This relates to the system not always being able to distinguish between different specialties within the Service that may be related to other services within the system.

Due to the way records have been captured within the system and potential gaps in the data, the categorised totals may not equal overall totals per Service.

Data that has been analysed includes All Wales Patient Experience data, Friends and Family Test data and Compliments data. The Big Thank You has been discarded in its entirety as the formatting of the data follows the same structure as pre 2021 data and therefore cannot be assigned to a particular service.

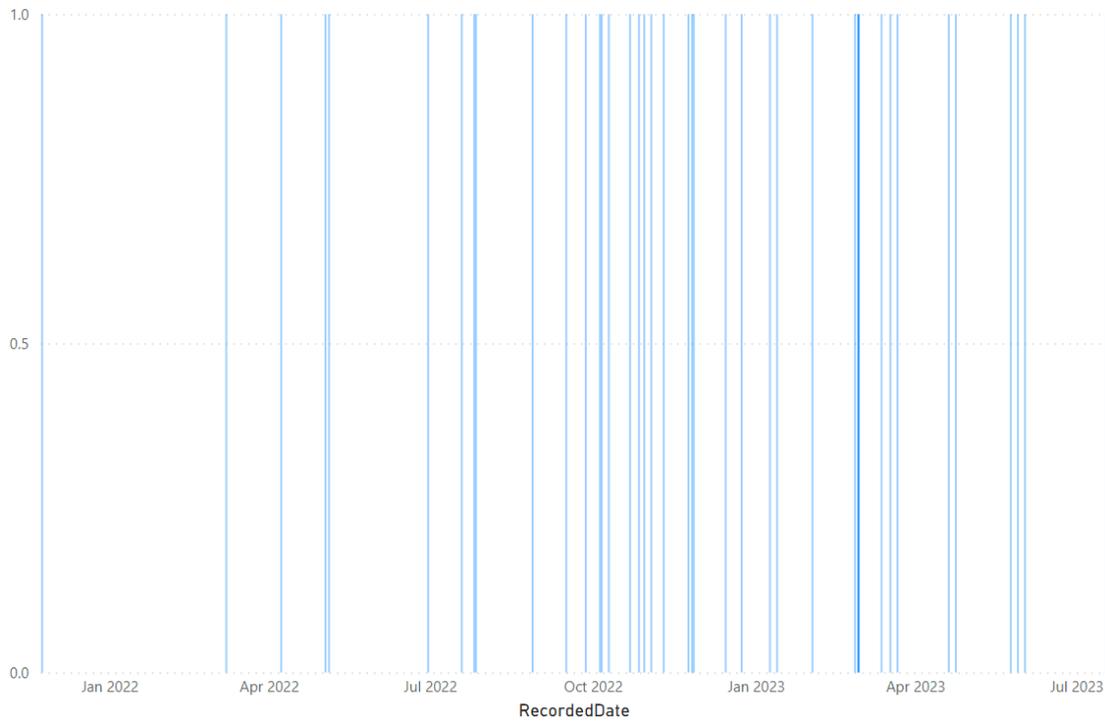
The thematic analysis was undertaken using Microsoft Copilot and has been used to provide a summary of themes per Service per year based on the patient feedback received.

Service Changes

The temporary services change in response to COVID commenced April 16, 2020, and is therefore out of the date range that has been analysed for this data.

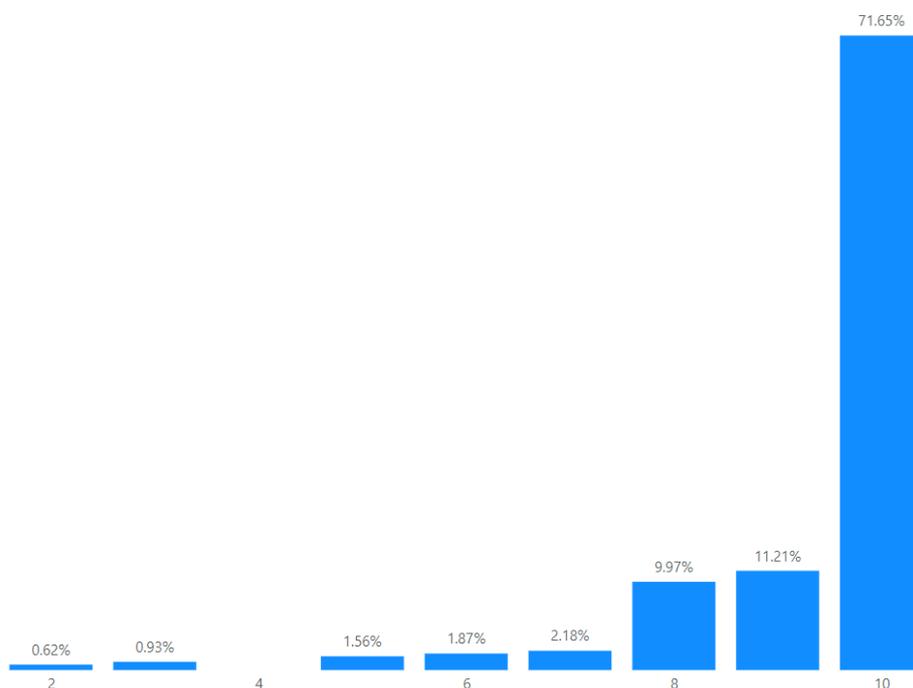
Patient Experience

All Wales Experience – Health Board Survey (1st April 2021 to 31st July 2023)



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021
			0	0	0	0	0	0	0	1	0	1
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022
0	0	1	1	2	1	3	1	2	6	5	2	24
Jan	Feb	Mar	Apr	May	Jun	Jul						2023
2	3	3	2	2	1	1						14

USING A SCALE OF 0-10 WHERE 0 IS VERY BAD AND 10 IS EXCELLENT, HOW WOULD YOU R...



Themes – 2021

Positive feedback around the friendliness of staff and quality of service provision

Themes – 2022

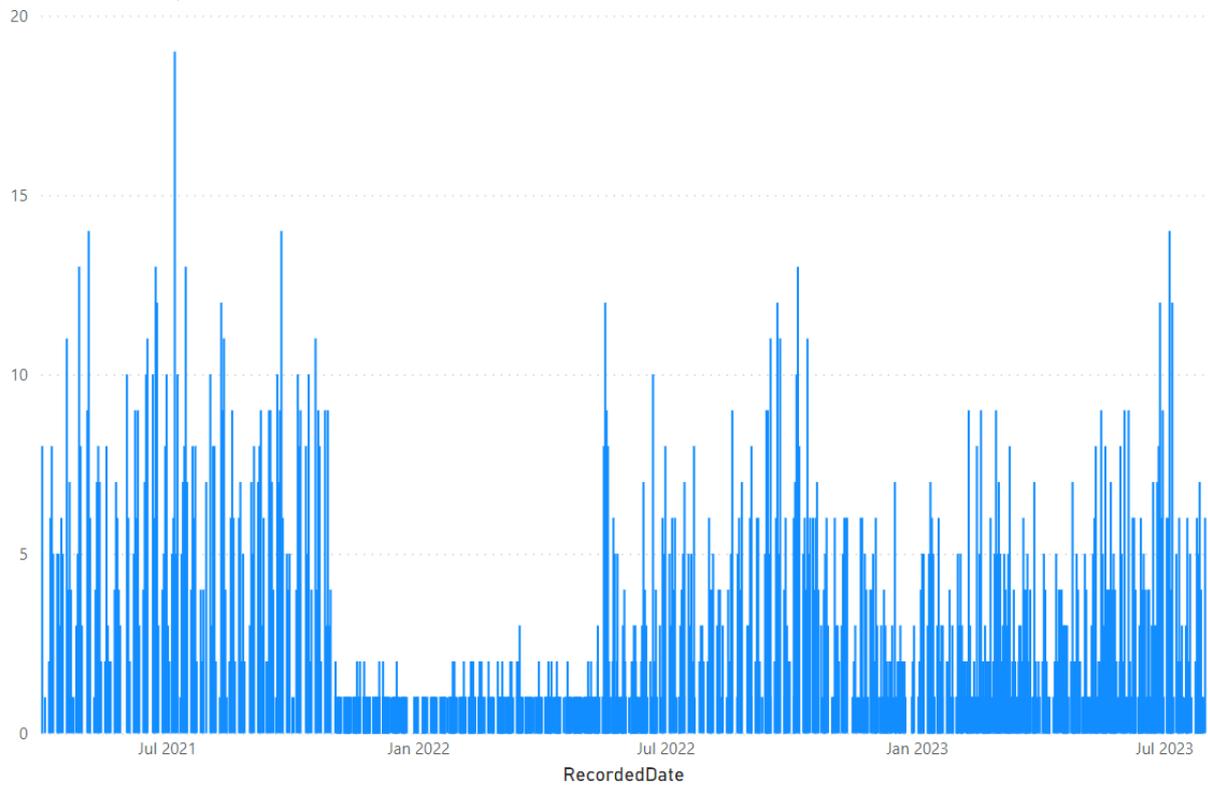
The themes noted by patients related to the quality of care, professionalism of staff and timeliness of appointments. Positive experiences include friendly and helpful staff, efficiency of service and quality of care. Negative experiences include the delays in waiting for follow up appointments which patients feel should be sooner, and for some accessing the service after locations were changed.

Themes - 2023

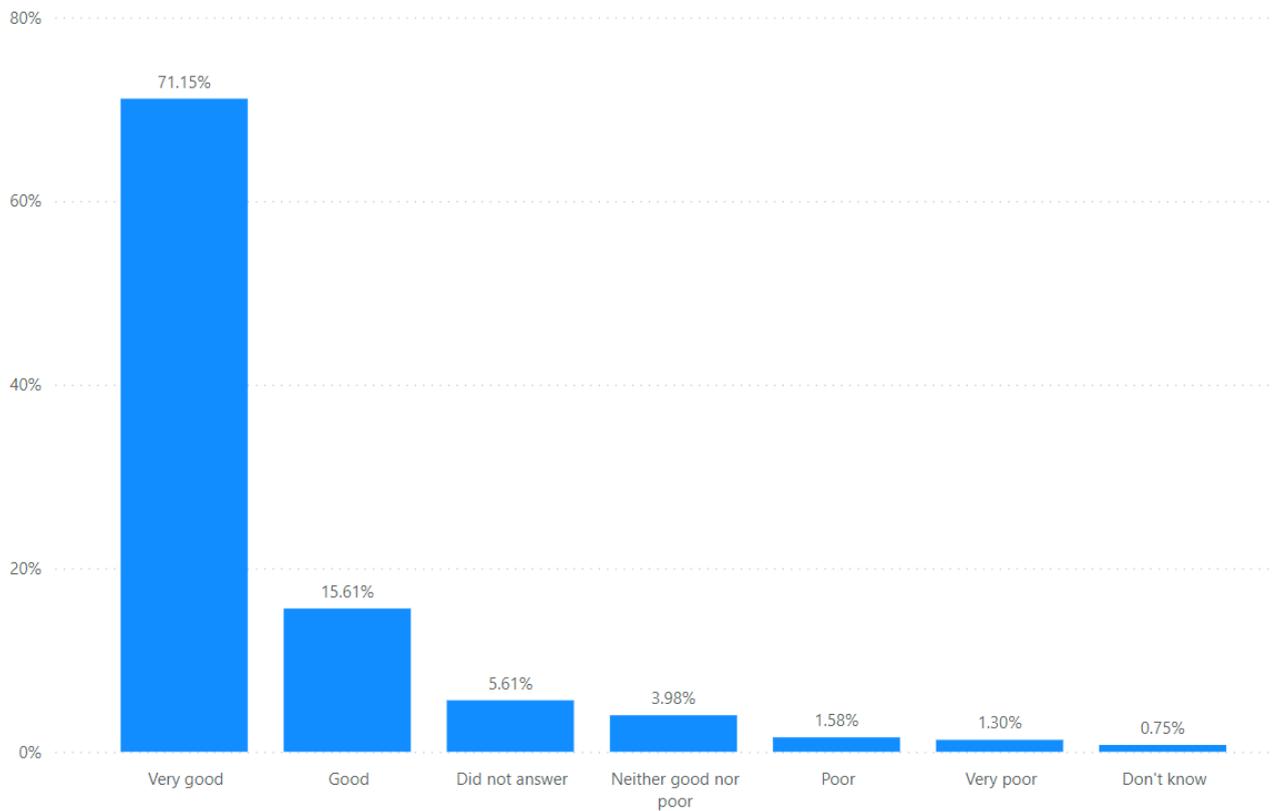
The themes arising relate mainly to staff professionalism, appointments, locations and access to services. Positive experiences include professionalism, kindness and quality of service. Negative experiences relate to delays or cancellations in appointments, uncertainty of the purpose of the appointment or status in the waiting list and the location being unsuitable for those who have had to drive to attend appointments.

Patient Experience

Friends and Family Test (1st April 2021 to 31st July 2023)



During this visit overall, how was your experience in this department?



Themes – 2021

The themes arising are related to staffing, the quality of care, communication and waiting times. Positive comments were received from patients reporting staff to be friendly, helpful and professional while delivering excellent care and attention to patients, looking after their comfort and wellbeing. Negative comments were around lack of communication between staff and with the patient about their care and treatment, perceived shortage of staff which had an impact of care and long wait times to be seen by a doctor or to receive treatment.

Themes – 2022

The themes arising are around staff, appointments, communication and impacts on people with disabilities. Positive comments were received around staff being described as friendly, helpful, polite and professional, with a quality of care being described as good with patients reporting good experiences with doctors and nurses generally. There were mixed views about waiting times for appointments with some being seen quickly while others faced delays or issues with scheduling appointments. Negative comments were received around how appointments were scheduled, mistakes with names, poor levels of communication from some doctors about how their care would be delivered and issues with parking on hospital sites. Patients also raised concerns about the impact of changes to the service of patients, particularly those with disabilities.

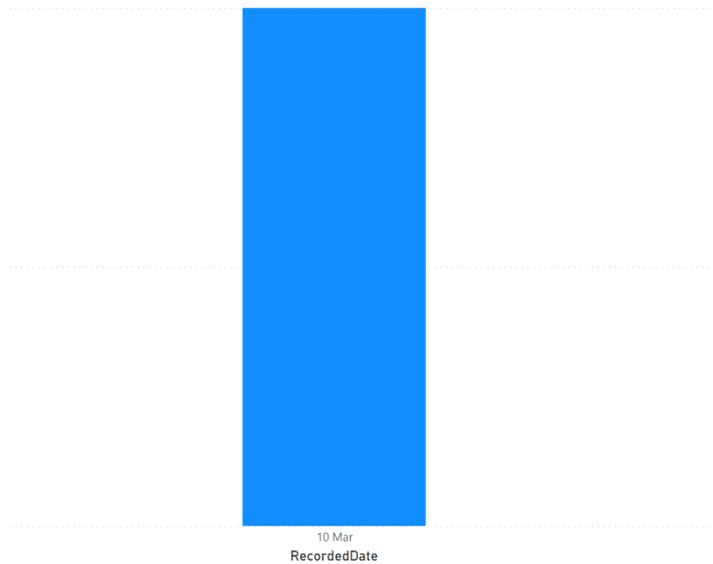
Themes - 2023

The themes arising are around staff, appointments, communications and impacts on people with disabilities. Positive comments were received around staff being described as helpful, caring, kind, thoughtful, friendly, and professional with quality of care being described as good with patients reporting good experiences with doctors and nurses generally. There were mixed views about waiting times for appointments with some being seen quickly while others faced delays or issues with scheduling appointments. Negative comments were received around how appointments were scheduled and the clarity and level of information provided about what their appointment was for. Patients also raised concerns about the impact of changes to the service on patients, particularly those with disabilities.

Patient Experience

Compliments (1st April 2021 to 31st July 2023)

DATE RECORDED



Recorded Date	Count
Mar 23	1

3 Sentiments that relate to Compliment

Sentiment	Count
Listening, Understanding, Communication	1

3 Health Board Values that relate to Compliment

Value	Count
Respect, integrity	1

Themes – 2023

The theme is that staff were proactive in identifying health needs getting patients the best possible outcome.

Workforce Data

Clinical Services Plan : Activity Modelling Workstream

OPHTHALMOLOGY



Glossary of terms

Term/Acronym	Definition
ESR	Electronic Staff Record – This is the National recording system within the NHS that houses all staff information. The majority of the workforce information contained within this report will have been extracted from the reporting functionality within the system.
WTE	Whole Time Equivalent – For the medical workforce 1WTE equates to 10 sessions or above. For all other staff working in the NHS under AfC terms and conditions 1WTE equates to a full time position of 37.5 hour working week.
AfC	Agenda for Change is the current NHS grading and pay system for NHS staff across Wales, with the exception of doctors, dentists, apprentices and some very senior managers.
Cost code	The Health Board Budget is structured to take into account all areas that incur a cost and is therefore broken down into different directorate areas. The cost code is the lowest level of organisational hierarchy which would denote the department/service/ward e.g. Ward 1
Staff group	There are 9 staff groups to which workforce will belong, dependent on their role. These are: Additional Professional Technical & Scientific; Additional Clinical Services; Administrative & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists; Medical & Dental; Nursing & Midwifery Registered and Students
TRAC	NHS Recruitment system
SLE	Single Lead Employment model – Since 2019, all Junior doctors are now under an SLE contract and co-located within NHS Wales Shared Services Partnership (NWSSP) ESR data to allow doctors to rotate across health boards easily.

Workforce Data Methodology overview

As part of the Activity Modelling workstream of the Clinical Services Plan the Strategic Workforce Planning team has provided the following report to assist the Workforce picture for the issues paper.

For the 9 Service areas noted, it is agreed that the Workforce data supplied will be based on the staffing consisted within the defined cost codes provided for each area. Where needed, additional information will be discussed with Service Managers as part of the current Task & Finish groups for each service.

As the scope of the project is to look at potential configuration changes for specific services, the workforce supporting the wider pathway will not be included within the data.

The data will focus on the clinical roles within the services i.e. Medical and Nursing workforce, but where available all professional group data from the cost codes will be presented.

To ensure any interdependencies are highlighted, any known workforce risks for the service will be included.

On the following pages the supplied cost codes for the service area are noted along with the intended outputs from each data set.

Due to the complexity of the workforce breakdown of some cost codes which can cover a number of service areas, where we may have not been able to disaggregate the specific workforce aligned to the service. Where these issues are raised within the data, this has been noted within the information provided.

Workforce Data Sources and outputs

Workforce Area	Data Source	Output
Current Workforce	ESR Staff In Post for: 31 st July 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the service areas based on cost codes supplied. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area). Where possible this will also include details of any Temporary Workforce utilised.
Workforce Risks	Risk Register / Datix: 31 st August 2023	Information on Current Service specific Workforce risks and any known interdependent service risks associated.
Historic Workforce Trend	ESR Staff in Post for 1 st April 2018, 1 st April 2019, 1 st April 2020, 1 st April 2021, 1 st April 2022, 1 st April 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the 9 service areas based on cost codes supplied for the period April 2018 to 2023. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area).
Starters & Leavers	ESR Staff Movements Yearly data for 1 st April to 31 st March for each year	Table/Graph denoting number of Starters and Leavers across each of the service areas. As above, where possible additional information will be provided for role and location however we are aware for leavers some of this data is not available within ESR.
Recruitment Issues	TRAC / Recruitment Team	Information in table or narrative format detailing any known targeted campaign activity for each of the service areas across the time period 2018– 2023. Additional data were available on volume of vacancies advertised in the last 12 months for each service.

Ophthalmology Workforce Overview 31st July 2023

Ophthalmology Workforce : Cost codes 0012, 0016, 0014, 0041, 0563, 0555, 0671, 1540 & 1648 (as of 31st July 2023)

Staff Group	Role	Location /Site						Grand Total
		Bronglais General Hospital	Glangwili General Hospital	Prince Philip Hospital	Withybush General Hospital	Amman Valley Hospital	North Road Clinic	
Additional Clinical Services	Health Care Support Worker		4.4		1.5			5.9
	Healthcare Assistant	0.6						0.6
	Technician		6.6		1.0		1.0	8.6
Additional Clinical Services Total		0.6	11.0		2.5		1.0	15.1
Administrative and Clerical	Clerical Worker	1.0	4.0		1.0			6.0
	Medical Secretary		3.0	1.0	0.8			4.8
	Officer		2.0			1.0		3.0
	Receptionist	1.0					0.4	1.4
Administrative and Clerical Total		2.0	9.0	1.0	1.8	1.0	0.4	15.2
Allied Health Professionals	Orthoptist		1.8		0.8		1.0	3.6
	Orthoptist Specialist Practitioner		0.6					0.6
	Allied Health Professionals Total			2.4		0.8		1.0
Medical and Dental	Consultant	2.0	5.0	0.8				7.8
	Specialty Doctor	1.0	7.0		2.0			10.0
	Medical and Dental Total		3.0	12.0	0.8	2.0		
Nursing and Midwifery Registered	Sister or Charge Nurse		2.6					2.6
	Specialist Nurse Practitioner		2.8			0.6		3.4
	Staff Nurse	1.7	6.1		3.3		2.6	13.7
	Nursing and Midwifery Registered Total		1.7	11.5		3.3	0.6	2.6
Total		7.3	45.9	1.8	10.4	1.6	5.0	71.9

The table above shows the workforce within Ophthalmology by role and location as of 31st July 2023.

Ophthalmology Workforce continued (as of 31st July 2023)

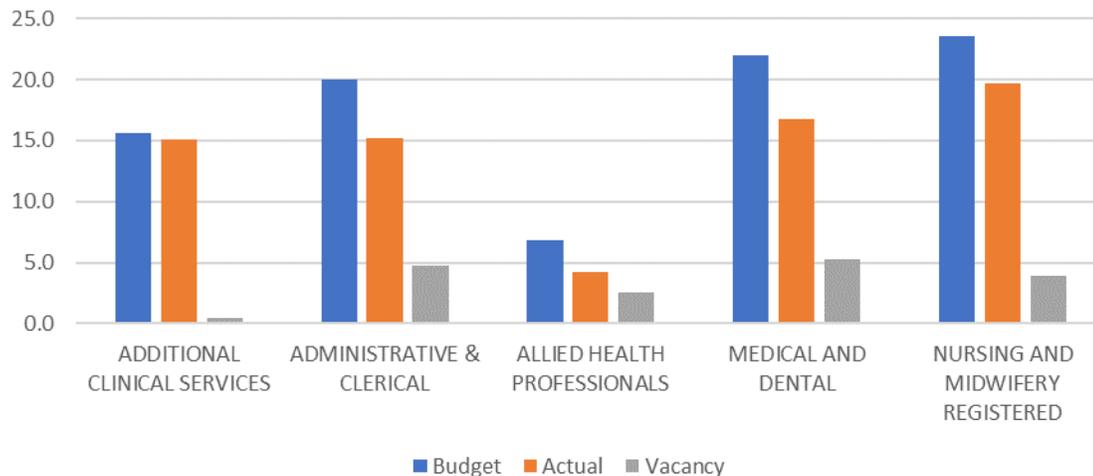
Staff Group	Budget	Actual	Vacancy
ADDITIONAL CLINICAL SERVICES	15.6	15.1	0.5
ADMINISTRATIVE & CLERICAL	20.0	15.2	4.7
ALLIED HEALTH PROFESSIONALS	6.8	4.2	2.6
MEDICAL AND DENTAL	22.0	16.8	5.3
NURSING AND MIDWIFERY REGISTERED	23.6	19.7	3.9
Grand Total	87.9	70.9	17.0

The table and graph show the Budget, Actual workforce WTE in post and the vacancies within Ophthalmology as of 31st July 2023.

At this time there was a total of 17WTE vacancies across the service, the highest vacancies can be seen in the Medical staff group with 5.3WTE, closely followed by Admin & clerical and Nursing vacancies (4.7WTE & 3.9WTE).

During this period an additional 0.76WTE of temporary staffing was utilised. This was through utilisation of Bank, overtime and additional hours. No agency staffing was used during this period.

Budget overview as of 31st July 2023



Workforce Risks

The below Workforce themed risks appeared on Datix (as of 31st August 2023).

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Measures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1670	P,C,LTC: Optometry	<p>There is a risk of that optometrists undertaking the Independent Prescribing course, many of which have been funded by the Health Board, will be unable progress without the placements being signed off by a suitably qualified ophthalmologist and therefore will not be able to sit their final exam.</p> <p>This is caused by the College of Optometrists interpretation of the General Optical Council's Regulations regarding the way independent prescribing placements must be supervised. Within the Health Board we have a suitably experienced ophthalmologist but is not listed in the Register in the required way. The only suitably qualified ophthalmologists have cited lack of capacity to support.</p> <p>This will lead to an impact/effect on the necessary expansion of the Independent Prescribing Optometric Service and the ability to implement Optometric Contract Reform efficiently. This will impact on increased pressure on other services such as GPs and the hospital eyeservice, as patients will need to be seen via these routes if there are no Independent Prescribers available. May lead to increased journey times for patients due to services only being available in Carmarthen and Aberystwyth. Reduced staff wellbeing and potential difficulty in retention and future recruitment of optometrists, as they will be unable to complete the placement or final common assessment. Reputational damage on the service and the Health Board. Potential financial loss due to the Health Board paying for these qualification.</p> <p>Risk location, Health Board wide.</p>	<p>Authorisation impacting progression of staff and service.</p>	Continuing with placements whilst looking for a resolution	10				Medical & Dental

Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Measures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1066	Scheduled Care: Ophthalmology	<p>"There is a risk that the Ophthalmology service will not be able to provide the level of outpatient clinics, IVT service, pre-operative assessment and RACE activity required.</p> <p>This is caused by the lack of nursing staff and health care support workers available as the service provided has increased and requires more staffing input, whilst the nursing establishment has not been reviewed to accommodate the service growth.</p> <p>This will lead to an impact/affect on disruption of the services being provided; inability to comply with The Nursing Staffing Levels (Wales); inability to cover planned and unplanned leave, risking cancellation of appointments and treatments.</p> <p>Risk location, Health Board wide."</p>	<p>vacancies, hard to fill vacancies in b5 post, DSU and OPD no longer able to support, retirement of staff - ageing workforce, staffing levels, establishment not grown with service</p>	<p>"WGH - Seeking support from colleagues at general OPD and DSU almost on a daily basis to cover regular clinic activity and staff absence (due to leave or sickness) 13/02/2023 update - DSU no longer able to provide support post-covid, and OPD team facing their own constraints, also unable to support. The establishment has increased by 1.3 WTE from the cataract business case to support cataract work in AVH, but there's been difficulty in recruiting to fill these vacancies. An advert for 1.0 WTE Band 5 has been advertised 3 times and it's still not filled.</p> <p>NRC - Offering staff overtime during the week to help cover regular clinical activity. 13/02/2023 update - Band 7 retiring and returning to support team. B3 currently on advert with renewed JD to support needs of the service. Ageing workforce in this team with potential for half of the team (4 or 5 staff) to retire in the next 5 years, who also constitute the specialist element of the workforce.</p> <p>Nurse injectors - Doctors upskilled to help cover for nurse injector absence/leave across all sites</p> <p>Across the Board - Implementation of telephone pre-op and telephone pre-op updates to better use nursing resources available - Mobilising staff between sites to help cover the clinical activity as required. - Review of activity changes and support we can request from units who have benefited from those changes.</p>	9	9	↔	RAG Rating	Nursing, HCSW - ACS

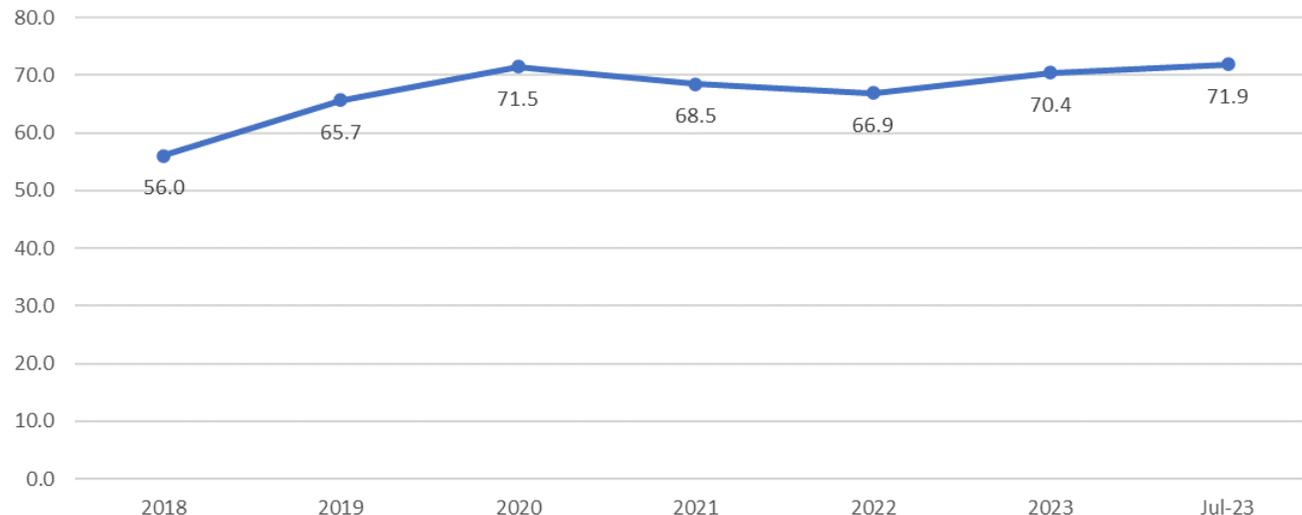
Ophthalmology Workforce Overview

Historic picture April 2018 – April 2023

Historic Workforce

The data below shows a historic picture of the ESR Staff in post for the Ophthalmology cost codes as at 1st April each year.

Ophthalmology Cost codes	2018	2019	2020	2021	2022	2023	Jul-23
Additional Clinical Services	8.4	12.4	15.5	12.1	12.0	14.7	15.1
Administrative and Clerical	12.0	16.2	14.4	16.2	14.2	15.2	15.2
Allied Health Professionals	2.0	3.0	4.2	4.2	4.2	5.0	4.2
Medical and Dental	16.4	17.0	17.8	17.3	16.1	16.8	17.8
Nursing and Midwifery Registered	17.3	17.1	19.7	18.7	20.4	18.8	19.7
TOTAL WTE	56.0	65.7	71.5	68.5	66.9	70.4	71.9



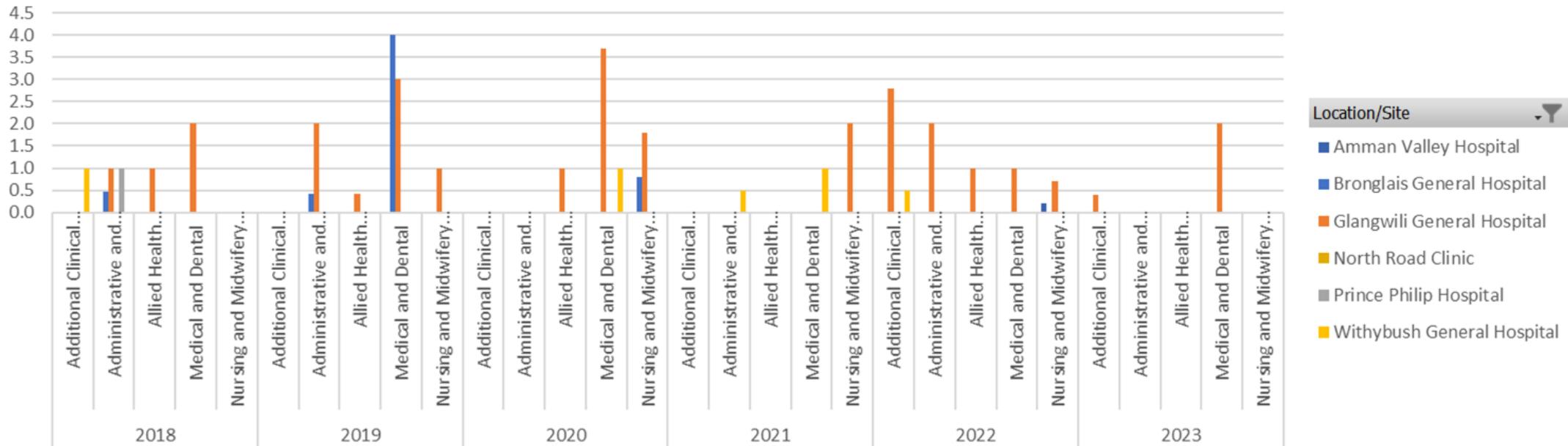
A steady increase in workforce can be seen between 2018 and 2020 with an increase of 15.5WTE however this followed with a slight decrease over the next two years. In the following 18 months the workforce has increased slightly and as of 31st July 2023 stood at 71.9WTE.

Additional service insights

ANY ADDITIONAL SERVICE INSIGHTS CAN BE ADDED HERE

Starters

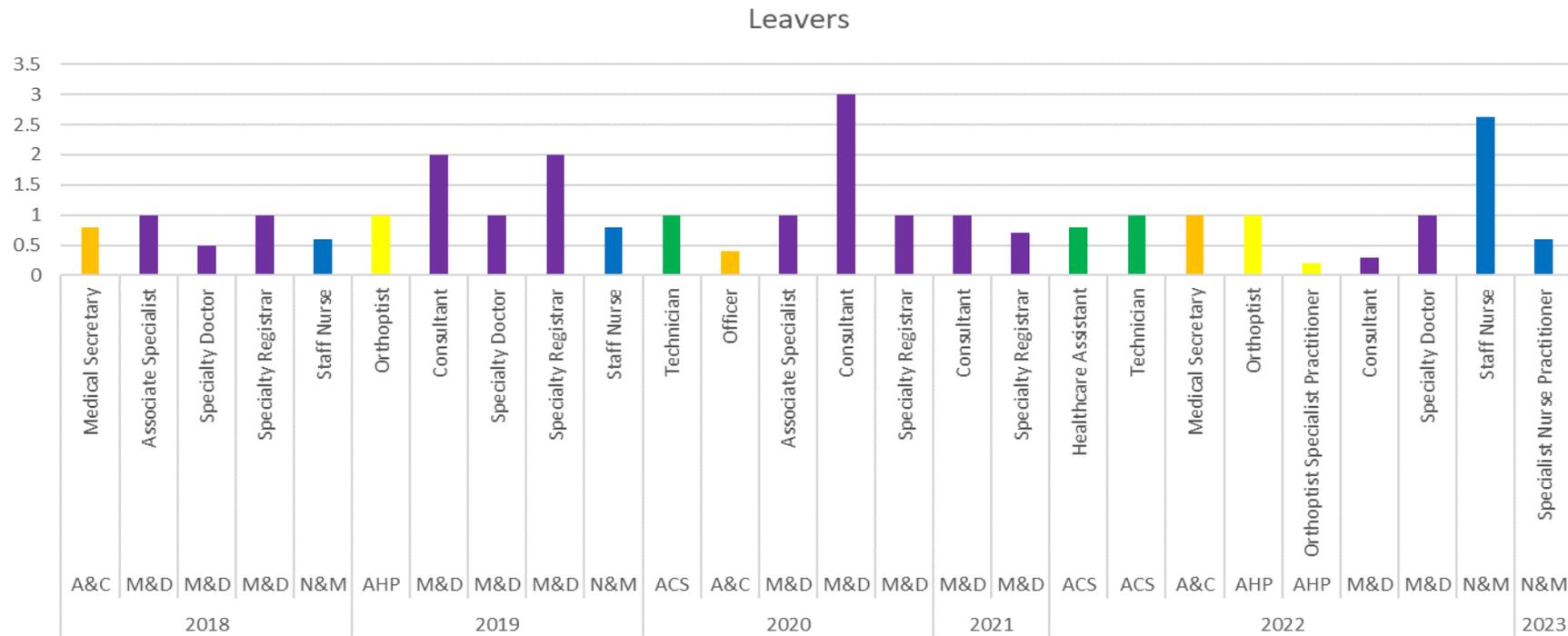
Sum of Starters FTE



	2018	2019	2020	2021	2022	2023
Starters	6.5	10.9	8.3	3.5	8.2	2.4

The largest increase in new starters was seen in 2019 in the Medical & Dental staff group with 7WTE. The highest increase of staff across the five year period was also in 2019 with 10.9WTE starting in the year, the majority in Glangwili hospital (6.4WTE).

Leavers



The majority of leavers across Ophthalmology have been within the Medical & Dental staff group (denoted in Purple). The highest number of leavers were in 2019 & 2020 with 5WTE leaving each year.

This correlates with the increase seen across 2019 and 2020 in starters (7WTE & 4.7WTE) within medical & dental across the same time period.

Leavers	2018	2019	2020	2021	2022	2023
Additional Clinical Services			1		1.8	
Administrative and Clerical	0.8		0.4		1	
Allied Health Professionals		1			1.2	
Medical and Dental	2.5	5	5	1.7	1.3	
Nursing and Midwifery Registered	0.6	0.8			2.6	0.6
Total	3.8	6.8	6.4	1.7	7.9	0.6

Recruitment

Targeted Campaigns across the period 2018 – 2023:

No targeted recruitment campaigns were noted during the period for Ophthalmology however adverts were placed in the British Medical Journal for the below Consultant Ophthalmologist and Locum Consultant in Ophthalmology posts.

Vacancy /Recruitment overview:

Vacancy Information (last 12 months)	Role	Outcome
100-MED-GGH-204	Specialty Doctor/Senior Clinical Fellow Ophthalmology	2 offered - 2 withdrawn
100-MED-GGH-204-A	Specialty Doctor/Senior Clinical Fellow Ophthalmology	2 offered - 1 withdrawn, 1 started in post
100-MED-GGH-204-B	Specialty Doctor/Senior Clinical Fellow Ophthalmology	1 rejected at interview
100-MED-GGH-130-B	Consultant Ophthalmologist	4 WTE advertised - 1 started in post.
100-MED-GGH-200-L	Locum Consultant in Ophthalmology	3 WTE advertised - 1 started in post, 2 scheduled for interview but both withdrew

Headhunting:

Targeted headhunting has taken place with 40 doctors headhunted via LinkedIn however there was no interest. Unable to find any doctors on the specialist register with UK experience who are looking to relocate to Wales.

Very hard to headhunt as service confirmed that the consultant posts would need to be on the specialist register with ideally UK experience.

Several attempts to attract doctors have failed.

Hywel Dda University Health Board Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Form 1: Overview

1.	What are you Equality Impact assessing?	The delivery of Outpatient Ophthalmology services in secondary care to service users in the Hywel Dda catchment area.
2.	Brief Aims and Description	<p>The Ophthalmology service in secondary care in Hywel Dda sits under the Scheduled Care division and constitutes a surgical specialty.</p> <p>Ophthalmology is organised into several subspecialties, which in turn include patients at different stages of access to specialist input, diagnostics, treatment and long term follow up.</p> <p>As part of the Outpatient delivery element, patients are seen in clinics / outpatient setting for the various subspecialties, such as:</p> <ul style="list-style-type: none">- Cataract- Glaucoma- Medical retina- Oculoplastics- Vitreoretinal- Intravitreal treatments- Laser clinics- Corneal- Paediatric Ophthalmology- Diagnostic tests (technician clinics)- Emergency clinics (Rapid Access Casualty for Eyes Clinic)- General (mixed) <p>The aim of this document is to provide an equalities overview for Ophthalmology services within Hywel Dda University Health Board.</p>
3.	Who is involved in undertaking this EqIA?	Victoria Coppack, Service Delivery Manager Marta Barreiro Martins, Senior Nurse Manager Amanda Sheldon, Service Manager

4.	Is the Policy related to other policies/areas of work?	<ul style="list-style-type: none"> - <u>All Wales Safeguarding Procedure (policy no. 868)</u> - <u>Clinical Record Keeping Policy (policy no. 195)</u> - <u>Equality and Diversity Policy (policy no. 133)</u>
5.	Who will be affected by the strategy / policy / plan / procedure / service? (Consider staff as well as the population that the project / change may affect to different degrees)	<ul style="list-style-type: none"> - All patients under and referred to the secondary care Ophthalmology service in Hywel Dda University Health Board - All staff working within and in partnership with the Ophthalmology service <ul style="list-style-type: none"> o Medical o Nursing o Allied Healthcare Professionals o Healthcare support workers o Technicians o Medical Photography o Medical Records o Admin and coordinators o Management team
6.	What might help/hinder the success of the Policy?	<p>Engagement from key stakeholders along the process will support the clinical service plan to successfully draw up all the required information to allow for a successful service review.</p> <p>Elements that might hinder the process relate to lack of resources such as staffing time and availability to engage with the process, lack of or reduced information available to inform the review as required.</p>

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the Policy relevant to:	Yes	No
<p>Article 2: The right to life</p> <p>Example: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control</p>	✓	
<p>Article 3: The right not to be tortured or treated in an inhuman or degrading way</p> <p>Example: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control</p>	✓	
<p>Article 5: The right to liberty</p> <p>Example: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control</p>	✓	
<p>Article 6: The right to a fair trial</p> <p>Example: issues of patient choice, control, empowerment and independence</p>	✓	
<p>Article 8: The right to respect for private and family life, home and correspondence; Issues of patient restraint and control</p> <p>Example: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life</p>	✓	
<p>Article 11: The right to freedom of thought, conscience and religion</p> <p>Example: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers</p>	✓	

How will the strategy, policy, plan, procedure and/or service impact on:	Positive	Negative	No impact	Potential positive and / or negative impacts Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.	Opportunities for improvement / mitigation If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.																																								
Age Is it likely to affect older and younger people in different ways or affect one age group and not another?	✓	✓		<p>Population Data</p> <table border="1" data-bbox="488 576 1182 1051"> <thead> <tr> <th>Age range</th> <th>Carmarthenshire</th> <th>Pembrokeshire</th> <th>Ceredigion</th> </tr> </thead> <tbody> <tr> <td>85 and over</td> <td>3%</td> <td>3.3%</td> <td>3.3%</td> </tr> <tr> <td>75-84</td> <td>8.1%</td> <td>8.8%</td> <td>8.5%</td> </tr> <tr> <td>65-74</td> <td>13.1%</td> <td>14.1%</td> <td>13.9%</td> </tr> <tr> <td>50-64</td> <td>21.8%</td> <td>22.2%</td> <td>21.3%</td> </tr> <tr> <td>35-49</td> <td>16.9%</td> <td>15.8%</td> <td>14.2%</td> </tr> <tr> <td>25-34</td> <td>11%</td> <td>10.5%</td> <td>9.9%</td> </tr> <tr> <td>20-24</td> <td>4.7%</td> <td>4.6%</td> <td>8.9%</td> </tr> <tr> <td>16-19</td> <td>4.2%</td> <td>4%</td> <td>5.8%</td> </tr> <tr> <td>15 and under</td> <td>17.3%</td> <td>16.9%</td> <td>14.1%</td> </tr> </tbody> </table> <p> How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk) How life has changed in Ceredigion: Census 2021 (ons.gov.uk) How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk) </p> <p>All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, with the most marked increase seen in Ceredigion (increased by 5 years to 47), followed by Pembrokeshire (increased by 3 years to 48) and Carmarthenshire (increased by 2 years to 42).</p>	Age range	Carmarthenshire	Pembrokeshire	Ceredigion	85 and over	3%	3.3%	3.3%	75-84	8.1%	8.8%	8.5%	65-74	13.1%	14.1%	13.9%	50-64	21.8%	22.2%	21.3%	35-49	16.9%	15.8%	14.2%	25-34	11%	10.5%	9.9%	20-24	4.7%	4.6%	8.9%	16-19	4.2%	4%	5.8%	15 and under	17.3%	16.9%	14.1%	
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Patient Information

Of a total of 16,153 patients, 1515 were under the age of 18 (9%), 5328 were between the age of 18-65 (34%) and 9310 are over the age of 65 (58%). This indicates that older people are disproportionately accessing the Ophthalmology service.

Certain eye conditions such as cataract and age-related macular degeneration (AMD) are directly caused as a result of the ageing process, and therefore are more prevalent in the older population. The number of patients presenting with these conditions is likely to continue increasing as the population becomes increasingly older.

[Causes/risk factors](#) | [Background information](#) | [Cataracts](#) | [CKS](#) | [NICE](#)

Age is one of the main risk factors to develop cataract, and most cataracts occur in people aged over 60 years old.

[Causes/risk factors](#) | [Background information](#) | [Cataracts](#) | [CKS](#) | [NICE](#)

Another significant risk factor for cataracts is diabetes, which increases the prevalence two-fold. This risk is higher for people at younger ages and with longstanding diabetes.

[Causes/risk factors](#) | [Background information](#) | [Cataracts](#) | [CKS](#) | [NICE](#)

In the UK, about 36,000 children under the age of 19 had diabetes in 2019. These are potentially a cohort of patients who will develop a cataract at a younger age.

[Incidence and prevalence](#) | [Background information](#) | [Diabetes - type 1](#) | [CKS](#) | [NICE](#)

Staff Information

Ophthalmology service staff age information:

Age Band	Headcount
21-30	6
31-35	7
36-40	18

41-45	12
46-50	11
51-55	13
56-60	14
61 & above	11
Grand Total	92

Positive Impacts:

All health board staff undertake equality (in particular Safeguarding Adults, Safeguarding Children and Dementia Awareness modules relating to age) as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

Negative impact:

Older people are disproportionately affected by the conditions noted above and make up the majority of patients within the service. This cohort of patients are frequently associated with age related disability.

Older people with the additional challenge of reduced eyesight may have difficulty accessing transport to attend secondary care. This could come with the added issue of access to toilet facilities in longer journeys, as the service is provided across a large geographical area, covering nine separate sites. If the patient is able to drive, there may be challenges around their vision driving in the dark. Older people may also have mobility issues or lack the confidence to use public transport.

Older people could potentially have the additional challenge of having a relative, friend or carer to attend secondary care with them.

Older people, especially when travelling long distance for their appointments, could potentially miss mealtimes and regular drinks, and are more susceptible to low blood sugar and an increased risk of dehydration and urinary tract infection.

There is a car/ambulance transport service available for eligible patients to use.

Patients travelling by car/ambulance transport or with additional needs are given priority in order to spend less time in the hospital premises, avoiding additional waiting time.

Older patients have access to free public transport. Hospital sites across the health board are located close to public transport routes and links.

All sites will have accessible toilets either directly in the service area or nearby.

Commented [ML(DUPM1)]: Review workforce induction pack

				<p>Wheelchairs are widely available at hospital entrances to be used by patients who have difficulty walking.</p> <p>Portering service is available to support patient mobility across the hospitals.</p> <p>When required, clinical staff will support the patients acting as a chaperone for their appointments or treatment, and as their advocate.</p> <p>On each site, staff will have access to facilities to provide the patient with basic drinks and biscuits. Larger sites have access to meals.</p> <p>Ensure compliance with mandatory training is kept up to date for all staff (see positive impact for age specific modules).</p>
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Disability

Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes

✓

✓

Population Data

	Carmarthenshire	Ceredigion	Pembrokeshire
Disabled under the Equality Act: Day-to-day activities limited a lot	21225 10.5%	6686 8.5%	12522 9.2%
Disabled under the Equality Act: Day-to-day activities limited a little	21897 11.1%	8951 11.5%	14651 11.1%

[How life has changed in Carmarthenshire: Census 2021 \(ons.gov.uk\)](#)

[How life has changed in Ceredigion: Census 2021 \(ons.gov.uk\)](#)

[How life has changed in Pembrokeshire: Census 2021 \(ons.gov.uk\)](#)

Patient Data

The patient data available is not reliable enough to advise if patients accessing the service are or are not disproportionately affected by disability. However, given most patients are over the age of 65, it can be assumed that there will be prevalence of age-related disability, as well as sight loss issues as the primary reason for accessing the service.

Staff Data

Disability	Headcount
No	78
Other	14
Grand Total	92

In 2020, 2.68% of staff in Hywel Dda identified as having a disability. From all the staff, 3,332 had not reported a disability status on ESR at the time the information was collected, so the disability figure might be higher than expected.

[H DUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](https://nhs.wales/hduhb-equalities-duties-reporting-staff-in-post)

Positive Impacts:

Patients with disability can have issues with:

- Understanding letters (dyslexia & other types of neurodivergence)
- Making enquiries/asking for help (communication difficulties)
- Difficulty sitting in crowded noisy waiting areas (autism) and facing long waiting times
- Difficulty attending appointments or other social engagements (OCD, bipolar, anxiety, depression)

All health board staff undertake equality training (including Paul Ridd Learning Disability Awareness, Safeguarding, Equality, Diversity and Human Rights, Autism Awareness and Mental Capacity Act) relating specifically to disabilities as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

The Health Board has available a series of resources as part of the Wellbeing Service, supporting staff with physical disorders and management of mental health and psychological concerns. [Staff Psychological Wellbeing Service](#)

All staff to maintain compliance with mandatory training.

The service will review all available patient documentation to ensure they comply with the required standards.

The Outpatients team are currently leading on a project to improve the signage in their hospital areas to ensure it is more accessible to patients.

Continue working with Estates to resolve the accessibility issues in the car park at Amman Valley.

Commented [ML(DUPM2)]: Review workforce induction pack

		<p>All main sites have hearing loops fitted into the Outpatients reception areas.</p> <p>It is Health Board policy to check that patient leaflets are easy to read, patient information available in easy read formats and different languages.</p> <p>There is a portering service available to support patient mobility across the hospitals.</p> <p>Place patients first on the list – go straight in, avoid crowded waiting rooms, use side/clinic room to wait.</p> <p>Negative Impacts:</p> <p>Patients with disability can have issues with:</p> <ul style="list-style-type: none"> - Locating the building/service within the building - Accessing the area physically – ramps, steps, accessible toilet, accessible rooms, wide doors, bariatric chairs/trolleys - Accessing accessible transport - Difficulty walking long distances <p>Older people are disproportionately affected by the conditions noted above and make up the majority of patients within the service. Even though all health board sites adhere to meeting minimum standards in terms of disabled facilities, concerns in relation to parking have been raised about both Glangwili and Amman Valley hospitals. In Amman Valley hospital, requests have been made to the Estates team to change the location of disabled car parking in order to place them closer to the ramp that gives access to the building. No actions have occurred to date.</p> <p>In Amman Valley, the accessible toilet in the main hospital building can be difficult to reach as it is located outside of</p>	<p>All sites will have accessible toilets either directly in the service area or nearby.</p> <p>All hospital sites adhere to minimum accessibility standards. Wheelchairs are widely available at hospital entrances to be used by patients who have difficulty walking.</p> <p>Staff in clinic need to be aware that patients may require support to access the toilet facilities.</p> <p>Place patients who will have difficulty sitting in a waiting room (this may include neurodiverse, physical disability etc) to be first on the list – go straight in, avoid crowded waiting rooms, use side/clinic room to wait.</p> <p>Hospital transport has cars and ambulances to support patients with different types of mobility concerns.</p> <p>The patient cohort who attend Amman Valley for surgery is specifically chosen to avoid highly dependent patients attending this site in particular for treatment.</p> <p>Patient trolleys and equipment used in the service have a display of the maximum load they can take, and staff are aware to verify</p>
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Commented [EH(DUSDa13)]: I think I know what this point is trying to say but maybe needs a little more text to clarify?

Commented [ML(DUPM4R3)]: Is there a procedure or policy to advise this? If so, reference it.

Commented [ML(DUPM5R3)]: Patients on transport are fast tracked to ensure they don't miss their appointments. No specific policy

			<p>Outpatients and at the top of a ramp, making the inclination and distance a barrier to some patients. There is no hoist available in the Amman Valley premises occupied by the service, however one can be borrowed from the ward if necessary.</p>	<p>this if determined necessary for bariatric patients. Wide trolleys and chairs are available to use for bariatric patients. Portering staff are available to support patients who are unable to walk long distances.</p>
<p>Gender Reassignment Consider the potential impact on individuals who either:</p> <ul style="list-style-type: none"> •Have undergone, intend to undergo or are currently undergoing gender reassignment. •Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth. 	<p>✓</p>		<p>Population Data</p> <p>In Carmarthenshire, 0.32% of people reported identifying with a gender different form the sex registered at birth.</p> <p>In Ceredigion, 0.70% of people reported identifying with a gender different form the sex registered at birth.</p> <p>In Pembrokeshire, 0.31% of people reported identifying with a gender different form the sex registered at birth. <u>Gender identity - Census Maps, ONS</u></p> <p>Patient Data</p> <p>There is no available information for Ophthalmology patients regarding gender reassignment.</p> <p>There is no anticipated need to know about gender reassignment information, therefore the service would not expect to require collecting this information.</p> <p>Patient confidentiality is maintained using health board guidelines regarding confidentiality.</p> <p>No impact is foreseen based on gender reassignment for patients.</p>	

			<p>Staff Data</p> <p>There is no available information for staff regarding gender assignment.</p> <p>Positive Impacts</p> <p>All health board staff undertake equality (Equalities, Diversity and Human Rights) training as part of mandatory competency training.</p> <p>All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.</p> <p>Each patient is reviewed on a case-by-case basis to ensure the patients' needs are tailored to their specific requirements to make their journey as easy as possible.</p> <p>Patient confidentiality is maintained using health board guidelines regarding confidentiality.</p> <p>Negative Impact</p> <p>Currently, no negative impact is foreseen based on gender reassignment.</p>	
<p>Marriage and Civil Partnership This also covers those who are not married or in a civil partnership.</p>		✓	<p>Population Data</p> <p>In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner.</p>	

Commented [ML(DUPM6)]: Review workforce induction pack

[How life has changed in Carmarthenshire: Census 2021 \(ons.gov.uk\)](https://ons.gov.uk)

In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner.

[How life has changed in Ceredigion: Census 2021 \(ons.gov.uk\)](https://ons.gov.uk)

In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner.

[How life has changed in Pembrokeshire: Census 2021 \(ons.gov.uk\)](https://ons.gov.uk)

Patient Data

Marital status	Nov 22 – Oct 23
Divorced	268
Married	3956
Separated	40
Single	1717
Widowed	521
Co-habiting	3
Blank/not known	8088
Total	14593

No impact on basis of marital status is expected for patients.

Staff Data

In 2020, 52.74% of staff in the Health Board were married, 1.44% were in a civil partnership, 31.37% were single, with 9.44% reporting being divorced, separated or widowed, and 5.01% not recorded on ESR.

[H DUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](https://www.nhs.uk/health-equalityities-reports/2020/2020-2021-hduhb-equalityities-duties-reporting-staff-in-post)

Marital Status of Ophthalmology staff	Headcount
Divorced/Legally Separated	9
Married	59
Single	19
Other	5
Grand Total	92

Currently, no impact is foreseen on the basis of marital status.

<p>Pregnancy and Maternity Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.</p>	✓	✓	<p>Population Data</p> <p>In 2021, there were 29,007 births registered across Wales. Maternity and birth statistics: 2021 GOV.WALES</p> <p>The estimated prevalence of cataracts calculated in 2020 for those aged 20-39 years was 3.01%. Prevalence Background information Cataracts CKS NICE</p> <p>Patient Data</p> <p>Patients are asked if they are likely to be pregnant during assessment. Data regarding pregnancy and maternity is currently not held by the health board.</p> <p>Staff Data</p> <p>In Hywel Dda, 4% of staff were reported to have maternity/adoption leave. It is unlikely that pregnancy and maternity will impact on the service, other than by potentially decreasing the number of staff available to cover the service.</p> <p>Positive Impact</p> <p>The Health Board has clear policies to address any pregnancy and maternity related highlighted risks, and Workforce and Occupational Health teams who can support with specific concerns.</p> <p>Negative Impact</p> <p>Being pregnant can impact on the ease of access the services and treatments, due to the number of appointments a pregnant woman</p>	<p>If alternative treatments are available they are discussed with the patient.</p>
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			<p>may have to attend across different services, in the first instance, and the impact certain treatments may have on the foetus, in the latter, and need to access alternative treatments.</p> <p>Where we know a patient is pregnant, risks involved in treatment upon the unborn baby are discussed with the patient. Each situation is reviewed on a case by case basis and a treatment plan agreed with the patient based on a risk assessment.</p> <p>Patients are assessed on an individual basis when the care required might potentially impact or be a risk for the health of the foetus or baby (if breastfeeding).</p>	<p>Risk assessments for staff are carried out and actioned when needed.</p> <p>If alternative treatments are available they are discussed with the patient.</p> <p>Risk assessments for patients are carried out and actioned when needed.</p>
<p>Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.</p>	✓	✓	<p>Population Data</p> <p>In Wales, 93.8% of the population identified as White, 2.9% as Asian, 0.9% as Black, 1.6% identified as 'Mixed or multiple ethnic groups' and 0.9% as 'Other ethnic group'. https://www.gov.wales/ethnic-group-national-identity-language-and-religion-wales-census-2021-html</p> <p>In Hywel Dda, 86.22% of staff identified as White, 0.91% as Black or Black British, 3.92% as Asian or Asian British, 0.48% as Mixed, 1.40% as 'Any other ethnic group' and 7.07% did not record their ethnicity on ESR. It is unlikely the staff ethnicity, race or nationality will impact or be impacted by these changes in the service. H DUHB EQUALITIES DUTIES REPORTING - Staff In Post (nhs.wales)</p> <p>Patient Data</p>	

Ethnic Background	Number of patients in last 12 months
Asian-GB Asian-Bangladesh	3
Asian-GB Asian-Indian	9
Black-GB Black-African	2
Black-GB Black-Caribbean	3
Chinese	7
Not stated	8473
Other Asian background	8
Other Black background	2
Other ethnic group	14
Other mixed background	4
White	6040
White - English	6
White - Polish	1
White - Welsh	14
White and Black African	2
White and Black Caribbean	5

Certain conditions are more prevalent in certain ethnic groups, for example, people of Asian ethnicity have a higher prevalence of cataracts than European people, and White people have a higher prevalence than Afro-Caribbean people.

[Causes/risk factors](#) | [Background information](#) | [Cataracts](#) | [CKS](#) | [NICE](#)

Staff Data

Ethnicity	Headcount
Not Recorded on ESR	7
BME	22
White	63
Grand Total	92

Positive Impacts:

			<p>All health board staff undertake equality training (including Equality, Diversity and Human Rights and Treat me fairly) as part of mandatory competency training. New employees of the health board will undergo a corporate induction process including 'Person Centred Approach' modules.</p> <p>Negative Impacts: A non-English or Welsh speaker may be unable to communicate to staff.</p> <p>The service are currently unaware if certain drugs that are delivered orally contain animal products that would be suitable for particular groups. All patients are asked if they are allergic to particular substances which will capture products a patient cannot be administered.</p>	<p>The Health Board has access to a translation service for patients who are unable to communicate in English or Welsh, and Health Board leaflets are available in different languages.</p> <p>The specialist pharmacy service can support when managing situations where a patient is known to be unable to be administered specific drugs.</p>
<p>Religion or Belief (or non-belief) The term 'religion' includes a religious or philosophical belief.</p>	✓		<p>Population Data</p> <p>In Carmarthenshire, 44.4% of people declared not having a religion, 47.6% are Christian and 6.2% did not answer; 1.2% were Buddhist, Hindu, Jewish, Muslim or Sikh and 0.6% replied with 'other'. How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)</p> <p>In Ceredigion, 43% of people declared not having a religion, 46.7% are Christian and 7.7% did not answer; 1.5% were either Buddhist, Hindu, Jewish or Muslim and 0.9% replied with 'other'. How life has changed in Ceredigion: Census 2021 (ons.gov.uk)</p> <p>In Pembrokeshire, 43% of people declared not having a religion, 48.8% are Christian and 6.6% did not answer; 1% were either Buddhist, Hindu or Muslim and 0.6% replied with 'other'. How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</p>	

Patient Data

Data regarding a person's religion or belief is not held by the service. However, when the service is aware of a person's religion or beliefs, adjustments to the care are made. Every patient is treated in an individual basis according to their needs.

Staff Data

In Hywel Dda, 39.94% of staff reported being Christian, 11.06% atheist, 19.01% did not disclose their religion and 19.92% did not record their religion on ESR. The remaining 10.07% recorded other religions.

[HDUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](#)

Religion	Headcount
Atheism	12
Christianity	34
I do not wish to disclose my religion/belief	28
Other	12
Unspecified	6
Grand Total	92

Positive Impacts:

All health board staff undertake equalities training (including Equality, Diversity and Human Rights) as part of mandatory competency training.

The Health Board has a Jehovah's Witness specific consent form which can be used if necessary.

Currently, no negative impact is foreseen based on religion or belief.

Negative Impacts:

All persons	187,897	100	71,475	100	123,360	100	382,732	100.0
Male	91,685	48.8	34,963	48.9	60,071	48.7	186,719	48.8
Female	96,212	51.2	36,512	51.1	63,289	51.3	196,013	51.2
Gender identity the same as sex registered at birth	144,924	93.2	55,874	91	95,794	93.4	296,592	92.5
Gender identity different from sex registered at birth but no specific identity given	210	0.1	84	0.1	121	0.1	415	0.1
Trans woman	93	0.1	73	0.1	58	0.1	224	0.1
Trans man	90	0.1	62	0.1	66	0.1	218	0.1
Non-binary	60	0	143	0.2	40	0	243	0.1
All other gender identities	38	0	66	0.1	32	0	136	0.0

Patient Data

Ophthalmology Patients	
Female	8090
Intersex	1
Male	6502

Women are more likely to enter the service, however they would not be impacted on their ability to access treatment.

Staff Data

As of 2020, 77.7% of staff in Hywel Dda were female and 22.3% were male. It is unlikely staff sex will affect or be affected by these changes in the service.

[HDUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](https://nhs.uk/health-board-equality-duties-reporting)

Gender	Headcount
Female	72
Male	20
Grand Total	92

Positive Impact:

All health board staff undertake equalities training (including Equality, Diversity and Human Rights) as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

There are male and female staff in the service and where possible, if a patient requests a specific gender of staff for their review, this will be provided.

If a staff member of a specific gender is not available, another staff member can be present during consultation as a chaperone.

Negative Impact

Commented [ML(DUPM7)]: Review workforce induction pack

Currently, no negative impact is foreseen on the basis of sex.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

✓

Population Data

Sexual Orientation	County							
	Carms		Ceredigion		Pembs		Totals	
	Value	%	Value	%	Value	%	Value	%
Total: All usual residents aged 16 years and over	155,486	100	61,391	100	102,551	100	319,428	100.0
Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
Bisexual	1,500	1	1,617	2.6	1,050	1	4,167	1.5
Pansexual	202	0.1	225	0.4	149	0.1	576	0.2
Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0	49	0.1	12	0	84	0.0
All other sexual orientations	19	0	16	0	7	0	42	0.0

Patient Data

Data regarding a patient's sexuality is not currently collected. There has been no evidence found regarding sexual orientation that may affect this cohort of patients. No impact based on sexual orientation is foreseen.

Staff Data

In Hywel Dda, 65.27% of staff reported being straight, 1.06% reported being gay or lesbian, 0.03% undecided, 0.46% bisexual, with 20.07% not recorded, 13.08% refused to answer, and 0.03% 'Other sexual orientation not listed'.

[HDUHB EQUALITIES DUTIES REPORTING - Staff In Post \(nhs.wales\)](#)

Sexual Orientation – Ophthalmology staff	Headcount
Heterosexual or Straight	65
Not stated (person asked but declined to provide a response)	21
Other	6
Grand Total	92

Positive Impact

All health board staff undertake equality training (including Equality, Diversity and Human Rights) as part of mandatory competency training.

All Health Board new starters to complete corporate induction as per policy at the start of their employment, including 'Person Centred Approach' training module.

Negative Impact

Currently, no negative impact on the basis of sexual orientation is foreseen.

Commented [ML(DUPM8): Review workforce induction pack

Armed Forces

Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed

✓

Population Data

	Carms	Ceredigion	Pembs	Total

Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:

[Armed-Forces-Covenant-duty-statutory-guidance](#)

Previously served in the UK regular armed forces	5610	1851	4654	12115
Previously served in UK reserve armed forces	1334	537	930	2801
Previously served in both regular and reserve UK armed forces	336	137	248	721
Grand total	7280	2525	5832	15637

Patient Data

Amongst all the adult patients who accessed the Ophthalmology services in a given 12 months' period (a total of 14,593), only two patients had declared an Armed Forces or Veteran status.

Positive impact

Some armed forces individuals are eligible for priority treatment, provided they adhere to the specific criteria as noted within the Welsh Government Armed Forces Covenant [Armed Forces Covenant: annual report 2021 \[HTML\] | GOV.WALES](#)

If their injury or illness is attributable to their military service then they are eligible for priority treatment.

If they were on a waiting list in another Health Board or even in England and they get posted (moved) to our Health Board area, then they are entitled to join the Health Board waiting list at the same point as when they left the previous location e.g. they had been waiting for an operation for two years and they join the waiting list here at the same point as someone who has been waiting two years and don't join at the end of the queue.

Negative Impact

No negative impact is foreseen for this cohort of patients when accessing the service.

Socio-economic Deprivation

Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: <https://gov.wales/more-equal-wales-socio-economic-duty>

✓

✓

Population Data

	County							
	Carms		Ceredigion		Pembs		Totals	
Economic Factor	Value	%	Value	%	Value	%	Value	%
Total: All usual residents aged 16 years and over	155,487	100	61,392	100	102,551	100	319,430	100.0
Economically active (excluding full-time students)	83,262	53.5	29,845	48.6	54,182	52.8	167,289	51.6
In employment	79,927	51.4	28,718	46.8	51,697	50.4	160,342	49.5
Unemployed	3,335	2.1	1,127	1.8	2,485	2.4	6,947	2.1
Economically active and a full-time student	2,612	1.7	2,119	3.5	1,352	1.3	6,083	2.2
In employment	2,025	1.3	1,401	2.3	1,068	1	4,494	1.5
Unemployed	587	0.4	718	1.2	284	0.3	1,589	0.6
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.2
Retired	43,170	27.8	16,997	27.7	30,306	29.6	90,473	28.4
Student	6,422	4.1	6,150	10	3,544	3.5	16,116	5.9

Looking after home or family	6,296	4	2,119	3.5	4,755	4.6	13,170	4.0
Long-term sick or disabled	9,710	6.2	2,730	4.4	5,632	5.5	18,072	5.4
Other	4,015	2.6	1,432	2.3	2,780	2.7	8,227	2.5

In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'Least deprived' or as second 'least deprived' in Wales. There is a number of areas identified as being nearer 'most deprived', which seem to be concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly. (Welsh Index of Multiple Deprivation 2019).

[Welsh Index of Multiple Deprivation \(WIMD\) 2019: results report \(gov.wales\)](#)

Patient Data

It can be difficult to ascertain the socio-economic status of our populations. One metric is employment status, which is detailed in the table above for the populations, but there is no patient specific data. However, given the primary patient group will be 55+, there will be a large number of patients who draw a pension attending the service.

Higher prevalence of cataracts is also directly associated with a lower educational or socioeconomic status.

[Causes/risk factors](#) | [Background information](#) | [Cataracts](#) | [CKS](#) | [NICE](#)

Smoking tobacco is also associated with the incidence and progression of cataracts, with those who stop smoking reducing their risk.

[Causes/risk factors](#) | [Background information](#) | [Cataracts](#) | [CKS](#) | [NICE](#)

Smoking is known to be more prevalent in least deprived areas, as per information presented by the Welsh Government. 'Whilst around 14%

of people in Wales are smokers, we know that those living in our more deprived communities are much more likely to smoke than those in the least deprived areas. The impact of tobacco use is a key component of the deep rooted health inequalities that Welsh Government want to tackle.'

[NMS Wales - A Smoke Free Wales](#)

Staff Information

There is currently no data available on socio-economic status for staff.

Staff's socio-economic status should not impact or be impacted by changes in the service, as any expenses incurred as part of travelling and education are reimbursed by the Health Board.

Positive Impact

There are several mitigation actions in place across the Health Board to minimise the impact of patients' or staff's socio-economic status in the way they access the Health Board for treatment or work.

Negative Impact

Hywel Dda University Health Board covers a very large geographical area, which may impact service users and staff when trying to access certain parts of the service that might only be delivered from sites which are not immediately local.

Due to various reasons, including lack of specialist staff or very specialised services, patients may need to attend other hospitals, as far as England sometimes (for example, Liverpool and Bristol), to access specific treatments. Due to distance from home, this can be very disruptive.

The Health Board has adopted savings schemes for staff to use, such as the Hapi app benefits for everyday discounts, the Leasing Car Scheme and Pool Car scheme, amongst many others.

Hywel Dda strives to deliver care closer to home whenever possible, which helps in reducing the amount of time the patients spend travelling, or unpaid work time the patients or their carers/family members need to take off to attend hospital care. For example, injection clinics are provided in all 3 counties to bring care closer to the patient.

Patients can claim travel expenses from the General Office in the hospital, or directly on the NHS Wales website, including travel to a specialist site such as Bristol

				<p>Eye Hospital. There is also information online on how to claim expenses when accessing care in the NHS in general, providing patient are eligible.</p> <p>Pensioners can access free public transport.</p> <p>When patients attend hospital outside of the Health Board for care, their care is transferred back to Hywel Dda as soon as possible.</p> <p>Staff are allowed to claim for travel expenses and may also be allowed to claim extra travel time spent travelling when working away from their usual base.</p>								
<p>Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.</p>	✓		<p>Population Data</p> <p>According to Welsh Census 2022 data, it is estimated that 29.5% of people aged three or older were able to speak Welsh. This figure equates to around 900,600 people. We are aware there are pockets of high Welsh speaking prevalence across the three counties.</p> <p>Patient Data</p> <table border="1" data-bbox="555 1265 1028 1394"> <thead> <tr> <th>Ophthalmic Patients</th> <th>Headcount</th> </tr> </thead> <tbody> <tr> <td>Dutch</td> <td>2</td> </tr> <tr> <td>English</td> <td>3185</td> </tr> <tr> <td>French</td> <td>1</td> </tr> </tbody> </table>	Ophthalmic Patients	Headcount	Dutch	2	English	3185	French	1	
Ophthalmic Patients	Headcount											
Dutch	2											
English	3185											
French	1											

Other	14
Polish	6
Unknown	5865
Urdu	1
Welsh	229
(blank)	5290

Staff Data

Welsh Language Level	Headcount
0 - No Skills / Dim Sgiliau	39
1 - Entry/ Mynediad	20
2 - Foundation / Sylfaen	4
3 - Intermediate / Canolradd	7
4 - Higher / Uwch	6
5 - Proficiency / Hyfedredd	7
Not Recorded on ESR	9
TOTAL	92

Positive impact

The Health Board adopted the Welsh Language Standards in 2019 across all directorates including Mental Health & Learning Disabilities Services. Following on from this a Welsh Language Services Report is produced annually.

In March 2021 the Bilingual Skills Policy was introduced across the health board. The main aims of the policy are as follows:

- To increase the use of Welsh within the workplace.
- To enable everyone who receives or uses our services to do so through the medium of Welsh or English, according to personal

Welsh language standards are applied to all health board staff.

Patient information is available in English and Welsh.

On average, one in five Ophthalmology staff are

		<p>choice, and to encourage other users and providers to use and promote the Welsh Language within the health sector.</p> <ul style="list-style-type: none"> To ensure staff are able to enact their right to receive services through the medium of Welsh within our internal administrative systems. <p>The health board uses its ESR system to capture Welsh Language information with 92% now showing an identified Welsh skill set. The skills set ranges from 0-5 with 0 being no Welsh language skills to 5 being fluent orally and written. Staff members identified at Level 3 and above can provide bilingual services to patients and carers.</p> <p>All service users and patients are offered a proactive service of Welsh language, which is recorded.</p> <p>The health board has developed a range of Welsh Language learning opportunities for all staff to learn and develop their skills, and time is given from work to attend. Since the Pandemic, these opportunities have been made available online which has seen an increase in uptake.</p> <p>A recent review of our current data tells us that it is easier to recruit Welsh Language speakers to lower banded posts as they tend to live locally. We have found that we are more successful in our recruitment of higher banded posts when specifically explaining the need for Welsh Language skills in the job requirements e.g., ability to speak Welsh is necessary but not the ability to write Welsh.</p> <p>Negative Impact</p> <p>Patients who would like to converse in Welsh, there may not always be a Welsh speaking staff member available.</p>	<p>Welsh language speaking staff at intermediate or higher level.</p> <p>The Health Board is very supportive of any staff who would like to learn or improve their Welsh speaking ability.</p> <p>Translation services are easily accessible when required, and all staff are trained on how to access them.</p>
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Form 4: Examine the Information Gathered So Far

1.	Do you have adequate information to make a fully informed decision on any potential impact?	Yes
2.	Should you proceed with the Policy whilst the EqIA is ongoing?	Yes
3.	Does the information collected relate to all protected characteristics?	Yes
4.	What additional information (if any) is required?	NA
5.	How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).	NA

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	3	-1	M
Disability	3	-1	M
Gender Reassignment	1	+2	P
Marriage and Civil Partnership	1	0	N
Pregnancy and Maternity	1	-2	L
Race/Ethnicity or Nationality	3	-2	H
Religion or Belief	1	+1	P
Sex	3	+1	P
Sexual Orientation	1	+1	P
Armed Forces	1	+1	P
Socio-Economic Deprivation	2	-2	M
Welsh Language	3	+2	P

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

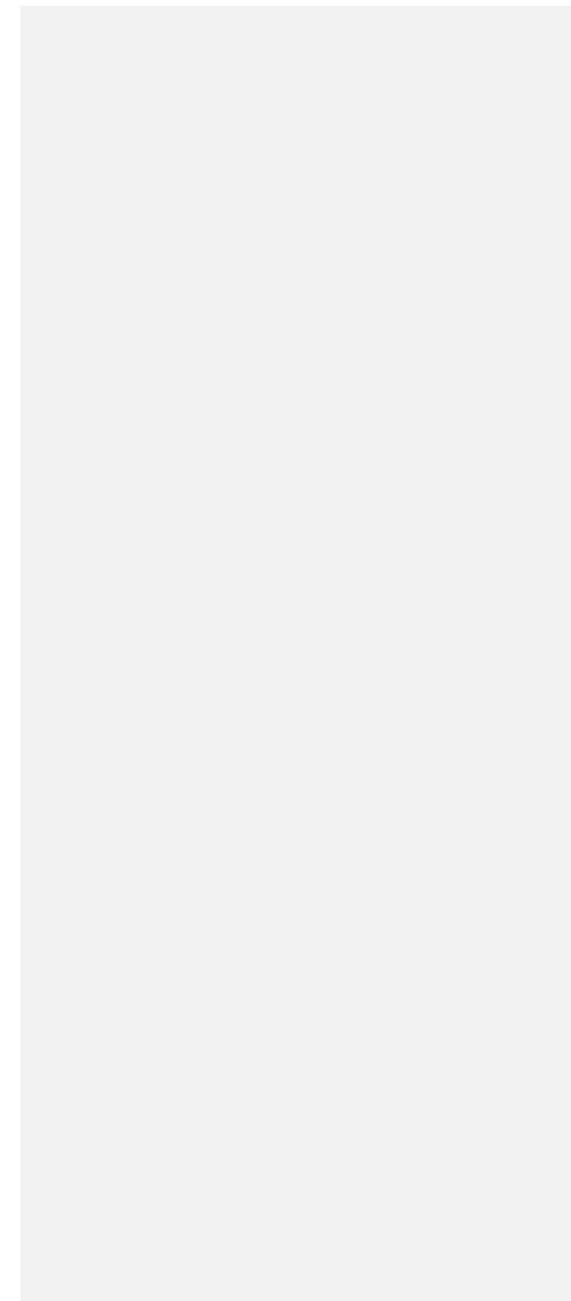
Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqlA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	This is a status quo EqlA based on an existing service
If No please give reasons and any alternative action(s) agreed.	NA
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqlA?	NA

What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?	NA
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	NA
Where positive impact has been identified for one or more groups please explain how this will be maximised?	NA
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.	NA



Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	Assigned to	Target Review Date	Completion Date	Comments / Update
Review where it is assumed there is no impact foreseen for protected characteristics: <ul style="list-style-type: none"> • Marriage and civil partnerships • Gender Reassignment • Sex • Sexual Orientation • Armed Forces 	Victoria Coppack	January 2025		
Any future staff engagement work to be carried out is to include staff networks.	TPO	Ongoing		
Review if the service needs to collect data regarding a patients smoking.	Victoria Coppack/Marta B. Martins	January 2025		
Review progress of the project to improve signage with outpatients team.	Ceri Wisdom/Damien Davies	January 2025		
Check with Pharmacy as to whether orally administered drugs contain animal products or not.	Marta B. Martins	April 2024		
Chase Estates about moving the disabled car park places in Amman Valley Centre closer to the disabled access ramp.	Victoria Coppack	January 2025		

Ensure mandatory training compliance with Equality training is 90% across all staffing groups.	Victoria Coppack / Marta B. Martins / Beca Phillips	January 2025		
Review all available patient documentation to ensure they comply with the required standards.	Victoria Coppack / Marta B. Martins	January 2025		

EqIA Completed by:	Name	Marta Barreiro Martins
	Title	Senior Nurse Manager
	Team / Division	Ophthalmology, Scheduled Care
	Contact details	Marta.barreiro.martins@wales.nhs.uk
	Date	05/02/2024
EqIA Authorised by:	Name	Victoria Coppack
	Title	Service Delivery Manager
	Team / Division	Ophthalmology, Scheduled Care
	Contact details	victoria.coppack@wales.nhs.uk
	Date	12/02/2024
Seen by Diversity & Inclusion Team:	Name	Eiddan Harries
	Title	Diversity and Inclusion Manger
	Team	Strategic Partnership Diversity & Inclusion
	Contact details	Eiddan.harries@wales.nhs.uk
	Date	02.02.2024