Archwilio Cymru
Audit Wales

Eye Care Review – Aneurin Bevan University Health Board

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This document has been prepared as part of work performed in accordance with statutory functions.

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Summary

About this report

1 Eye care services are becoming more important as the UK population ages. An ageing population means there are more incidences of age-related eye conditions, such as cataracts, age-related macular degeneration, and glaucoma. Many, if caught early, can often be managed effectively with existing treatments and medicines. But delays can also result in increased risk of harm and irreversible sight loss. As a result of the increased risk of harm, in 2019 NHS Wales introduced the 'Eye Care Measure' which is an approach for prioritising and measuring waiting times based on clinical condition and risk of harm. Ophthalmology waits also continue to be recorded and reported as part of the wider referral to treatment time metrics.

2 In March 2021, the Welsh Government published NHS Wales Eye Health Care – Future Approach for Optometry Services. The plan forecasts a long-term growth in the prevalence of major eye conditions over the next 20 years including:

- 47% increase in the numbers of people with age-related macular degeneration;
- 50% increase in the numbers of people having cataracts; and
- 44% increase in the numbers of people living with glaucoma.

3 At the end of May 2025, across Wales, 32,683 ophthalmology patient pathways had waited over a year for treatment and 1,730 over two years, and 20,283 over a year for their first outpatient appointment[1]. The three health boards with the most challenging position in respect of ophthalmology waits are Aneurin Bevan, Cardiff and Vale, and Cwm Taf Morgannwg University health boards.

4 Given these challenges Aneurin Bevan, Cardiff and Vale, and Cwm Taf Morgannwg University Health Boards committed to work in partnership and launched the 2022-2025 South East Wales Regional Ophthalmology Strategy (the regional strategy). Aneurin Bevan University Health Board is the lead organisation for the regional ophthalmology programme. The Auditor General has included a review of eye care services within his local audit plans for all three health boards.

5 This report sets out the findings of our work at Aneurin Bevan University Health Board (the Health Board). We reviewed local and regional plans to improve eye care services, leadership arrangements to drive improvements and address barriers to progress; and whether the Health Board is actively managing the harms resulting from long ophthalmology waits.

6 The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with

[1] Data source: Referral to treatment times, Welsh Government.

INTOSAI[2] audit standards. **Appendices 1 and 2** provide more information about our work.

Key messages

Overall conclusions

7 Whilst the Health Board has been able to reduce its longest ophthalmology waits, it has not met the Welsh Government's planned care recovery targets. Performance against the 'eye care measure' is poor and, as a result, some patients are likely to be coming to avoidable harm.

8 In the context of these challenges, there is a need to strengthen local planning of eye care services, broaden the scope of regional working, secure further productivity and efficiency gains, and strengthen board and committee oversight of ophthalmology services.

Key issues

Regional partnership working

- Delivery of the regional eye-care approach sets out a positive direction of travel. However, it was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity for cataract procedures.
- The regional cataract approach is targeting long waits, but it is not making a marked difference on overall numbers of patients waiting for treatment.
- Governance arrangements to oversee regional strategy delivery are in place, but the process for decision making on business cases can be slow and cumbersome involving multiple groups across the three Health Boards.

Health Board plans for eye care services

- The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer-term service needs.
- The Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, but it has not yet led to sustained improvements.
- Ophthalmology service capacity remains a concern, with consultant vacancies and a 30% reduction in the ophthalmology medical workforce between March 2021 and March 2025.

[2] International Organisation of Supreme Audit Institutions

Leadership and governance

- There is good executive, clinical and operational leadership that is focussing on driving short-term improvements in eye care services.
- There is insufficient Board and committee oversight of eye care services. In particular, the Patient Quality Safety and Outcomes committee should receive clear assurance on the harms caused as a result of a delay and lessons learnt.
- Risk management arrangements do not adequately cover eye-care risks.

Ophthalmology performance

- While referral to treatment ophthalmology waits over two years have significantly reduced, the Health Board has missed the Welsh Government's target for those waiting longer than one year. Since April 2023, waiting lists have grown from around 19,000 waits to over 23,000 waits.
- The Health Board has consistently failed to meet the Welsh Government's eye-care measure target. Most recent nationally reported performance is 44.3%, falling substantially short of the 95% target.

Managing the risk of harm

- While appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Regional ophthalmology strategy R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases. (**See paragraph 17**) R2 Regional partners should develop a resource plan, to better understand the operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy. (**See paragraph 18**) R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy. (**See paragraph 18**)
Health Board plan for eye care services R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: • based on current and projected future demand for services; • includes capacity plans based on realistically ambitious levels of productivity; • costed, at a minimum, for the medium term (three to five years); • supported by resource plans ie financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; • supported by clear delivery actions and milestones; • approved by the Board. (**See paragraph 26**) R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery. (**See paragraph 38**)
Managing eye care risks R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed. (**See paragraph 40**)

Recommendations

Managing the risk of harm

R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on:

- how patients on the ophthalmology waiting list are managed to prevent harm;
- lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and
- actual harm caused by ophthalmology waiting delays. (**See paragraph 54**)

Detailed report

Regional partnership working

10 We considered whether the regional ophthalmology strategy supports the delivery of sustainable ophthalmology services, and whether there are appropriate governance arrangements in place to support its implementation.

11 We found that **while now progressing, delivery of the regional eye-care approach was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity.**

12 In 2022, Cardiff and Vale, Cwm Taf Morgannwg, and Aneurin Bevan University Health Boards launched the 2022-2025 Regional Ophthalmology Strategy (the regional strategy). It responds to key issues from the 2021 Pyott Review[3], including rising demand, limited specialist capacity, and reliance on English providers.

13 The strategy sets out a clear vision for sustainable, high-quality services. It aims to establish a Regional Centre of Excellence and deliver complex eye care regionally, while less complex care is provided closer to patients' homes.

14 The regional strategy identifies key clinical risks, including sight loss from long waits, rising demand, and workforce shortages. It sets high-level targets for 2023–2025, including expanded cataract and emergency services, a regional vitreoretinal service, workforce development, and plans for a Regional Centre of Excellence.

15 Aneurin Bevan University Health Board is the regional lead for the new partnership approach, with involvement and engagement from its regional partners. The programme is split into three phases with annual milestones, these are:

- by 2023: Regional expansion in capacity for cataracts will be fully utilised, a Regional Vitreo Retinal Service will be operational, Regional Eye Casualty and Out of Hours Care will be in place (**Phase 1**);
- by 2024: Research, Innovation and Development will be well established, a Workforce Development Programme will be in place (**Phase 2**);
- by 2025: Regional Centre of Excellence network funding will be agreed (**Phase 3**).

16 While governance arrangements to oversee regional strategy delivery are clear, there is a risk that the structure is too complex, causing delays. The Regional Ophthalmology Programme Board meets monthly and is supported by the Delivery and Development Group. Both have clear objectives, effective management, and strong clinical engagement from each health board. The Programme Board reports to the Regional Portfolio Oversight Board, which oversees all regional programmes. In April 2025, the Cabinet Secretary for Health and Social Care instructed the south-east region to further establish a joint regional committee during 2025-26.

17 While decisions are being made through the established governance groups, they are also being taken separately by each health board. For example, the business

[3] External Review of Eye Care Services in Wales (rcophth.ac.uk) undertaken by Andrew Pyott

case for regional cataract services required approval at ten different meetings, resulting in delay. The creation of the joint regional committee presents an opportunity to also consider how delegated authority and decision-making processes are streamlined (**Recommendation 1**).

18 Phase 1 of the strategy aimed to expand key regional services by 2023, but overall progress has been slower than planned. The focus on creating regional cataract service capacity was pragmatic because of the waiting list backlog, but slow to progress. Other elements of the regional strategy have also been slower to deliver, particularly those set out in phases 2 and 3 above relating to a specialist centre of excellence and research. There are many factors constraining progress. This includes the focus on short-term planning detracting attention from the longer-term priorities, and operational and clinical workforce challenges (**Recommendation 2**). To help better monitor strategy delivery, there needs to be clearer reporting against the original strategy commitments, setting out clear delivery timescales (**Recommendation 3**).

19 It is clear that the new regional arrangements are creating new service activity in addition to the core activity provided by each Health Board. In July 2023, the Welsh Government agreed £7 million recurrent funding to deliver the Regional Cataracts Business Case. From a slow start, particularly because of recruitment challenges in the Nevill Hall north hub, the levels of cataract procedures have now increased (**Exhibit 2**).

Exhibit 2: Profiled and actual delivery of cataract procedures facilitated by recurrent Welsh Government funding, by delivery hub

Financial year	Provider		Profiled	Actual
2023-24	South hub		2905	2764
	North hub		39	26
	Regionally outsourced		750	676
		Total	**3694**	**3466**
2024-25	South hub		2049	1930
	North hub		950	846
	Regionally outsourced		1308	1308
		Total	**4307**	**4084**

Source: Aneurin Bevan University Health Board

20 While the regional cataract approach is targeting long waits, it is not making a marked difference on overall numbers of patients waiting across the region. The funding used for regional working is being used to treat patients waiting a long time

for cataracts services. However, there are more people on the referral to treatment ophthalmology waiting list now then there were in March 2023. In March 2023, there were 45,930 patients waiting across the region and this increased to 54,977 by 2025. Without the regional investments, the position would have been worse, but the regional arrangements are not yet significantly resulting in a reduced overall level of ophthalmology waits.

21 In October 2024, the Welsh Government awarded the region a further £7.5 million of non-recurrent funding to help reduce the long waits, particularly those waiting more than two years. Following Ministerial Advisory Group recommendations, and supported by £19.5 million of non-recurrent funding, the region may further increase its use of the independent sector during 2025-26.

22 To support equitable access to treatment, regional capacity has not been distributed equally across the three health boards. Instead, it has been focused on patients who have been waiting the longest. Because the proportion of very long waits are not the same across the health boards, the Welsh Government has provided more regional funding to Cwm Taf Morgannwg University Health Board than the others. This targeted allocation aims to reduce waiting lists in a way that promotes fairness across the region. While this may not appear a 'fair share', it reflects a practical and equitable approach to addressing variation in access across the region. This approach is also supported by a regional booking team, helping to ensure more consistent access to treatment.

Health Board plans for eye care services

23 To ensure patients receive timely eye care in an appropriate setting, and prevent avoidable, irreversible harm, it is essential that the Health Board has a clear plan to improve its current, community and hospital-based eye care services and develop a sustainable model of care for the future. We considered whether there are realistic plans to improve eyecare services at a local level, considering whether:

- the Health Board has an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges; and
- the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services.

24 We found that **the Health Board's planning approach for local eye care is fragmented and lacks clear long-term direction, and while steps have been taken to improve efficiency, these have yet to deliver sustained results.**

Local eye care plans

The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs

25 The Health Board has a good understanding of the barriers to improving eye care services. These include growing service demand, insufficient workforce capacity and inadequate digital and estates infrastructure. However, the Health Board does not have an overarching eye care plan to guide long-term service improvement and address these challenges. Instead, its eye care priorities are articulated in several plans. These include the Health Board's Annual Plan, the supporting ophthalmology service plan, eye care action plan covering hospital and community eye care, and focused plans such as implementing the Getting it Right First Time (GIRFT) recommendations and Welsh General Ophthalmic Services (WGOS) pathways[4]. Whilst there is crossover between these plans, the current approach is uncoordinated and short-term in nature. The Health Board recognises the need to develop a single eye care plan and is in the early stages of this process.

26 The Health Board has recently developed an eye care action plan. The action plan is aligned to the National Clinical Strategy for Ophthalmology, which was launched in October 2024, mirroring its strategic themes[5]. The Health Board reported that it is in the process of developing an approach to deliver its action plan. Initially, it will focus on priority areas, with task and finish groups being established to progress work in these areas. The task and finish groups[6] will report to the Eye Care Board. While this progress is positive, the eye care action plan is high-level, the timescales for delivery are unclear, as are the Health Board's long-term ambitions for eye care services. Given the challenges with ophthalmology waiting times, the Health Board must urgently complete its eye care plan, which should be Board approved, to guide long-term, sustainable service improvements (**Recommendation 4**).

27 In the short term, the Health Board's service intentions are effectively shaped by demand, capacity and what can realistically be delivered. Each service, including ophthalmology, completes an annual planning template, which includes high-level demand and capacity planning. This helps the Health Board understand current pressures and plan accordingly. For example, the ophthalmology annual plan compares planned and actual activity, such as referrals, outpatient appointments,

[4] The WGOS (Wales General Ophthalmic Services) pathway is a structured framework designed to enhance eye care services in Wales.

[5] The strategic themes are organisational reform, clinical networks, pathway transformation and sustainable delivery model.

[6] The task and finish groups are as follows: ophthalmology cataract group, regional ophthalmology delivery and development group, medical retina clinical reference group, estates accessibility group and digital ophthalmology groups.

and emergency admissions, to adjust plans for the following year and identify capacity gaps.

28 The approach above supports the development of a sustainable eye care plan by providing clearer insight into long-term resource needs. However, the capacity of the ophthalmology service is a concern. The Health Board has had three long-standing vacancies for ophthalmology consultants. Encouragingly, all positions have now been successfully filled; however, two of the appointed consultants are not expected to commence their roles until August 2026. In overall terms, the Health Board has seen a 30% decrease in its ophthalmology medical workforce between March 2021 and March 2025[7].

Plans for improving service efficiency

While the Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, it has not yet led to sustained improvements

29 The Health Board is focussing on improving efficiency and productivity. It aims to increase theatre utilisation, increase cataract surgery productivity and reduce outpatient inefficiencies. It also seeks to optimise optometrist roles by implementing the WGOS pathways and upskilling hospital optometrists. Similar measures are outlined in the Health Board's Annual Plan for the planned care service, which includes ophthalmology. This pragmatic approach supports sustainable services by maximising use of current resources. The eye care action plan also addresses broader barriers, with workstreams targeting waiting times, regional collaboration, workforce development, integrated care, and digital transformation.

30 Despite the past and current focus on productivity and efficiency, there are significant opportunities for improvement. As at 4 August 2025, the theatre utilisation rate for the ophthalmology service was 80% against the Health Board target of 90%, the average late start and early finish theatre rates were 37% and 49% respectively, the short notice theatre cancellation rate was 11.9%, attributable to both the patient and hospital, and the 'Did not Attend' rate for new ophthalmology outpatients was 8.4%[8].

31 The report from the Ministerial Advisory Group on NHS Wales Performance and Productivity also makes recommendations to reduce unwarranted variation in treatment waiting times and adopting best practice in theatre management. This includes a recommendation to create Local Theatre Optimisation Boards to boost

[7] In March 2021, there were 18 full time equivalent ophthalmology medical staff, compared to 12.5 in March 2025. Data source: Welsh Government medical workforce data.

[8] Data source: Aneurin Bevan ophthalmology referral to treatment compelling scorecard, fiscal week 19. Figures shown are based on a 12-week rolling average.

productivity within theatres, and best practice of cases per theatre session. For ophthalmology this means ten cataract procedures in a four-hour theatre session, and eight procedures if it is a training session. Currently, the Health Board's cataract surgery lists include seven to eight patients per list. In June 2025, the service successfully trialled a ten-patient cataract list, with an improvement plan in place to consistently deliver high-volume lists.

Leadership and governance arrangements

32 Clear leadership and governance arrangements are key to supporting well managed service improvement. We considered whether the Health Board has:

- clear and effective executive, operational and clinical accountability;
- appropriate Board and committee level oversight and scrutiny; and
- appropriate arrangements to capture, manage and oversee operational and corporate risks.

33 We found that **there is good executive, clinical and operational leadership to drive short-term improvements, but there is insufficient Board oversight, and risk management for eye-care services needs improving.**

Operational and clinical leadership

The Health Board has good executive, clinical and operational leadership to drive short-term improvements in eye care services

34 The Health Board has clear leadership and accountability for its eye care services, with the Chief Operating Officer overseeing both acute and primary care. The ophthalmology service, within the surgery division, is led by a strong triumvirate leadership team. The team is made up of an ophthalmology directorate manager, clinical director and two senior ophthalmology nurses. The service has appropriate executive and operational clinical leadership, which oversees clinical governance, performance, and incidents, while community optometry contracts are overseen by the Primary Care Divisional Lead and a dedicated optometry professional lead.

35 In general, we found good executive and operational oversight of ophthalmology performance. Performance is reviewed routinely through the Health Board's Planned Care Programme Board structure, Chief Operating Officer's directorate performance assurance meetings, surgery directorate meetings and ophthalmology service meetings. Oversight mechanisms tend to focus on improving waiting times and service efficiency and productivity, which are valid but have a short-term focus.

36 The Health Board has re-established its Eye Collaborative Care Board and Eye Care Working Group. The Eye Care Working Group is responsible for overseeing development of the Health Board's overarching eye care plan. This should improve the focus on longer-term service improvements.

Board and committee oversight

There is insufficient Board and committee oversight of eye care services

37 Board level oversight of eye care services needs strengthening. While various committees receive updates, these are often ad-hoc or embedded within other reports. This makes it difficult to fully understand the totality of service, quality and performance risks. Ophthalmology is featured within the planned care update of the integrated performance report received by the Finance and Performance Committee and the Board, but ophthalmology performance is not separated. The Patient, Quality, Safety Outcomes Committee receives various reports where ophthalmology is mentioned, such as the Primary Care Annual Quality Report and the Putting Things Right Annual Report. Only the Partnership Population Health and Planning Committee receives consistent updates focused on regional ophthalmology work.

38 In June 2024, the Health Board conducted a comprehensive ophthalmology deep dive, but this has not featured in any committee papers, neither have updates against the ophthalmology GIRFT recommendations. Given the level of risk posed by the ophthalmology waiting list, there needs to be a greater level of Board assurance. Once the eye care plan has been approved by the Board, an appropriate committee should receive routine progress updates (**Recommendation 5**).

Risk management arrangements

Risk management arrangements do not adequately cover eye-care risks

39 Generally, the Health Board's ophthalmology directorate and surgery division risk registers capture operational risks. These include issues with medical equipment, follow-up outpatients over their target dates, retina clinic capacity, estate issues, specialist ophthalmic nursing capacity and difficulties recruiting a cornea specialist. However, we note some fundamental gaps, such as risks related to current gaps in the paediatric and glaucoma ophthalmologist workforce and inadequate digital infrastructure, especially related to the use of Open Eyes electronic patient record. The Health Board should review its ophthalmology service risk register to ensure all risks are adequately managed. The Health Board is currently developing its approach to managing corporate risks.

40 Our 2025 planned care review found that planned care risks, including ophthalmology, are reported to the Planned Care Programme Board. However, there is no Planned Care Programme Board specific risk register, which may result in some risks or mitigating actions not being effectively tracked or prioritised. At Board level, the Health Board's strategic risk register includes several risks which

are relevant to ophthalmology, such as those related to maintaining high quality and safe services, and inadequate digital and estate infrastructure. However, there is insufficient focus on the risk of patient harm associated with treatment delays (**Recommendation 6**).

Ophthalmology performance

41 We analysed ophthalmology waiting list performance and trends to determine whether the Health Board is meeting Ministerial priorities and Welsh Government national targets related to reducing long waiting lists. The targets are as follows:

- no one waiting longer than a year for their first outpatient appointment by the end of 2022 (target date revised to December 2023);
- eliminate the number of people waiting longer than two years in most specialities by March 2023 (target date revised to March 2026); and
- eliminate the number of people waiting longer than one year in most specialities by Spring 2025.

42 In addition, ophthalmology services are measured using the eye-care measure. This measures the extent of delay for those patients at most risk of harm because of a delay in treatment. This approach is explained in **Exhibit 4.**

43 We found that **while long waits over two years for ophthalmology have significantly reduced, the Health Board continues to fall short of the Welsh Government's targets for the eye-care measure and patients waiting over one year.**

Performance against Welsh Government planned care targets

While ophthalmology waits over two years has significantly reduced, the Health Board has missed the Welsh Government's target for those waiting longer than one year

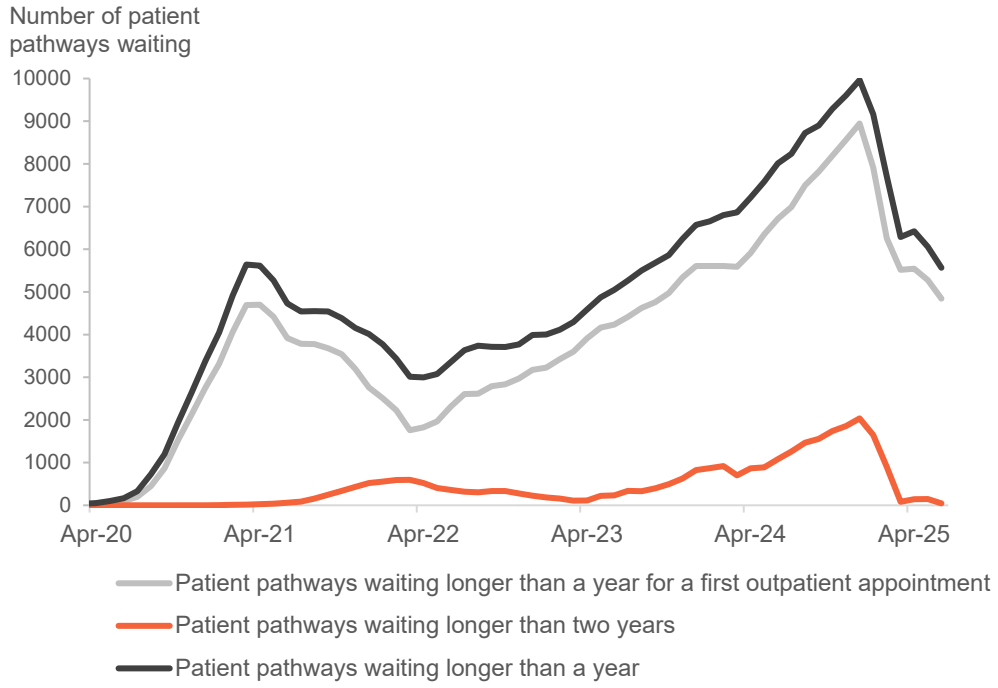
44 **Exhibit 3** shows the Health Board's performance against the Welsh Government planned care waiting list targets. In June 2025 the Health Board had:

- 5,567 patients waiting longer than a year on the ophthalmology waiting list;
- 4,842 patients waiting longer than one year for their first ophthalmology outpatient appointment; and
- 44 patients waiting longer than two years on the ophthalmology waiting list.

45 All three measures have seen a general deterioration since the pandemic. Whilst there has been some improvement from January 2025 onwards, the improvements coincide with additional Welsh Government non-recurrent funding to address long cataract waits. Between April 2021 and April 2025, the Health Board has seen a 51% increase in ophthalmology referrals. Overall referral to treatment waits in the last two years has increased from around 19,000 to over 23,000. This growth,

alongside the long-term trends identified in **Exhibit 3**, suggests that the Health Board needs to do much more to address both long waits, and the overall level of waits.

Exhibit 3: the number of ophthalmology patients waiting longer than two years and one year, Aneurin Bevan University Health Board



Source: Referral to treatment times, Welsh Government

Eyecare measure waiting list performance

The Health Board has consistently failed to meet the Welsh Government's eye-care measure target, falling substantially short of the 95% target

46 In addition to the referral to treatment time waiting list, NHS Wales reports patient waits for those who are most at risk of harm because of a delay. **Exhibit 4** provides a basic explanation of this measure.

Exhibit 4: A basic introduction to the eye care measure

The Welsh Government introduced the eye care measure to help prioritise those most at risk of harm as a result of a delay in accessing services.

Ophthalmology patients are risk assessed based on their condition and then given a target date to be seen. If a patient who is categorised as the highest risk (R1)[9] waits 25% longer than the clinically assessed target date, then it counts as a breach.

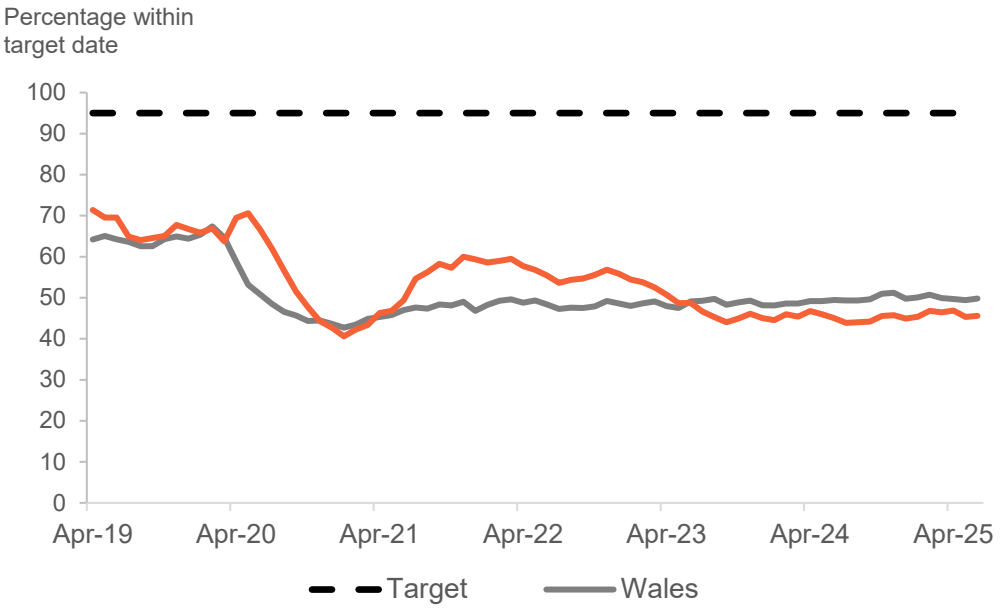
Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in four weeks. Mrs Jones waits just over six weeks – therefore the target has been breached. Within five weeks, this would not have been a breach.
The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

Source: Audit Wales

47 **Exhibit 5** shows performance against the Welsh Government eyecare measure target. Since July 2023, the Health Board's performance has dropped below the Welsh average and has not recovered. In June 2025, performance was 45% against the national target of 95%. Patients identified as Health Risk Factor R1 have an increased potential risk of harm and permanent sight loss.

[9] The highest risk is known as Risk Factor 1 or R1. R1 category is for patients that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

Exhibit 5: Percentage of eye care patients seen by their target date or within 25% beyond their target date, Aneurin Bevan University Health Board



Source: Eye Care Measure performance, Welsh Government

48 The Health Board's performance against the eye care measure remains a significant concern and means that there is a real and continued risk of patients coming to avoidable harm and suffering irreversible sight loss.

Managing the risk of harm

49 Patients' eye conditions may deteriorate while waiting, causing pain, anxiety, affecting their quality of life and ability to work or care for others. It is important that the Health Board actively manages harms associated with long waiting list delays. We considered whether the Health Board:

- has effective processes to record and report on incidence of harm that results from eye care waiting list delays; and
- is taking appropriate action to manage the risk of patient harm, particularly sight loss.

50 We found that **while appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.**

51 The Health Board has appropriate mechanisms in place to prioritise its waiting list. It uses a risk stratification tool, as recommended by the GIRFT review, to prioritise ophthalmology patients based on clinical need, with R1 patients at highest risk. A separate tool supports glaucoma care decisions, helping to determine whether patients can be managed by community optometrists or require hospital care.

52 Waiting list validation is primarily carried out by validation clerks with clinical input. Some of the validation clerks are relatively new and training is being provided to support more complex case management.

53 The Ophthalmology Service has several processes to identify and review harm. It has invested in a senior nurse dedicated to reviewing current and historic ophthalmology harms recorded on the DATIX system. Regular patient safety meetings and weekly Executive Hub reviews support oversight of serious incidents, some of which may trigger Duty of Candor or the Welsh Government's serious incidents process. These reviews help identify learning, shared through forums such as clinical audit meetings and ophthalmology team meetings. They also help correct patient pathways and prioritisation, which may be lost or delayed on the waiting list.

54 The Health Board reported that between July 2024 and July 2025, ten ophthalmology-related incidents involving delays were recorded on Datix. Nine concerning delays in patient assessment and one in treatment. Of these, two were graded as low harm, five as moderate harm, and three as severe harm. We have seen evidence of serious incidence and harm being reported through executive performance reviews, a service specific deep dive and monthly eye care measure reports. While executive and operational oversight arrangements for ophthalmology harms and serious incidents are sound, there is very little reporting of actual ophthalmology harms to the Patient, Quality, Safety Outcomes Committee or assurances that lessons are being applied to reduce the risk of harm in future (**Recommendation 7**).

Appendix 1

Audit methods

Exhibit 6 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Regional Ophthalmology Strategy, associated programme management documentation and progress reports • Local eye care plans (ophthalmology and optometry), delivery/implementation plans and progress reports • Documentary evidence on the use of Welsh Government funding • Performance dashboards/reports related to eye care services • Documents related to programme governance and oversight arrangements related to delivery eye care plans, harms reviews and learning from incidents of harm • Plans or proposals for insourcing/outsourcing/ waiting list initiatives • Operational risk register(s) for eye care services • Documents showing procedures, including responsibilities, for clinical assessment of patients on the ophthalmology waiting list
Interviews	We interviewed the following: • Chief Operating Officer • Deputy Medical Director • Deputy Director of Nursing • Ophthalmology Directorate Manager • Assistant Ophthalmology Directorate Manager • Ophthalmology Consultant and Clinical Director • Senior Nurse Ophthalmology • Senior Interim Nurse Ophthalmology • Assistant General Manager Surgery • Primary Care Divisional Lead • Primary Care Ophthalmology Lead • Consultant ophthalmic surgeon

Element of audit methods	Description
	• Chair of Patient, Quality, Safety Outcomes Committee • Regional Eye Care Programme Lead
Observations	We observed the South East Wales Regional Ophthalmology Programme Board.
Data analysis	We analysed key ophthalmology service data on: • waiting list performance; • referrals; • medical workforce; • outpatient and inpatient activity and efficiency; • surgical cancellations; and • inpatient and day case admissions.

Appendix 2

Audit criteria

Main audit question: **Does the Health Board have effective arrangements to improve eye care services?**

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
Does the Health Board have realistic plans to improve eyecare services at a regional and local level?	Does the Health Board have an agreed plan to improve eye care services, covering hospital and community services, which seeks to address current and longer-term challenges?	• The Health Board has a clear eye care plan, which has been approved at Board level which: – seeks to address current and future challenges with a view to developing sustainable eye care services; and – supports delivery of the Health Board's strategic objectives/priorities and aligns with the ambitions set out in national strategies/plans and legislation. • The eye care plan appropriately reflects regional plans, which the Health Board is invested in, which aim to deliver sustainable ophthalmology services on a regional basis.
	Is the Health Board's eye care plan realistically deliverable?	• The eye plan is supported by/includes a clear delivery plan with clear actions and milestones. • The eye care plan is based on current and projected future demand for services. • Capacity plans are based on realistically ambitious levels of productivity. • The plan is costed, at a minimum, for the medium term (three to five years). • The plan is deliverable within the resources available to the Health Board.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Do the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services?	• The Health Board is proactively targeting and improving eye care service efficiency in a range of areas such as reducing DNAs and cancellations in outpatients and surgical settings, improving surgical productivity (particularly cataracts), maximising eye-care theatre list utilisation, and utilising see on symptom and patient initiated follow-ups. • Plans include national and local performance and efficiency measures, and draw upon the work of GIRFT reviews where relevant. • The Health Board is working with others effectively to drive wider efficiency improvements. • The Health Board is making use of digital systems to improve service efficiency. • Use of outsourcing has been considered/implemented as a mechanism to help reduce waiting list backlogs, supported by the necessary considerations of value for money and service safety.
Does the Health Board have appropriate leadership arrangements to drive improvements in eye care services and address the barriers that might inhibit progress?	Are there appropriate governance and leadership structures to drive forward the necessary improvements?	• There is clear Executive and Senior Management accountability for the delivery of eye care improvement plans. • There is clear clinical leadership for the delivery of eye care improvement plans. • There is evidence of operational oversight of the delivery of eye care improvement plans. • There is evidence of oversight and scrutiny of the delivery of eye care plans at the appropriate Committee and at Board. • Risks are appropriately captured within operational and corporate risk registers. • There are escalation mechanisms in place in the event of services failing to meet required standards/targets/milestones.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Is the Health Board identifying and addressing the barriers to improving its eye care services?	• The Health Board has a clear understanding of the barriers that might prevent it delivering its eye care improvements/improvement plans and intentions. • The Health Board can demonstrate that it is putting in place arrangements to tackle the barriers that could impede delivery of the improvement plans.
	Is the Health Board effectively delivering its improvement plans for eye care services?	• The Health Board can demonstrate that it is making good overall progress implementing eye care plans and initiatives, and the achievement of milestones, targets and outcome measures identified within its plans.
Is the Health Board actively managing the risk of harm resulting from ophthalmology waiting list delays?	Does the Health Board have effective approaches to record and report on incidence of harm that results from eye care waiting list delays?	• The Health Board has appropriate arrangements to identify, capture, and report on harm associated with long waits for eye care treatment: – there is a clear process for identifying and capturing patient harm caused by delays to eye care treatment; – the Health Board is reporting on actual harm caused by delays to eye care treatment to its Quality and Safety Committee; and – the Quality and Safety Committee receives assurances that the Health Board is learning from incidence of harm to prevent it in the future.
	Is the Health Board taking appropriate action to manage the risk of patient harm, particularly sight loss?	• The Health Board has an appropriate system to assess patients on the eye care waiting list to ensure those most at risk of sight loss are treated first. • The eye care waiting list is frequently reviewed by a clinician to ensure clinical risks are up to date and correctly prioritised. • The Health Board is managing potential health inequalities in access to eye care services.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
		• The Health Board is applying the principles of Welsh Governments' promote, prevent, and prepare policy to help patents on eye care waiting lists.

Appendix 3

Management response

Exhibit 7 below sets out the Health Board's response to our recommendations.

Recommendation	Management response	Completion date	Responsible officer
R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes.	December 2025	Chair of Regional Ophthalmology Programme Board
R2 Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 2025-26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	March 2026	Chair of Regional Ophthalmology Programme Board

Recommendation	Management response	Completion date	Responsible officer
R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result ,the Regional Strategy will be reviewed as part of the programme plan in 2025-26, with appropriate phasing and timeframes assigned to programme priorities.	March 2026	Chair of Regional Ophthalmology Programme Board
R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: • based on current and projected future demand for services; • includes capacity plans based on realistically ambitious levels of productivity; • costed, at a minimum, for the medium term (three to five years); • supported by resource plans ie financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models.	The Health Board acknowledges the urgency and importance of completing the Eye Care Plan and is actively progressing work to meet the outlined requirements. The following steps are being taken to ensure the plan is robust, sustainable, and Board-approved: **1. Demand-Based Planning** • The draft Eye Care Plan has been completed. • Ophthalmology capacity and demand modelling takes place yearly, ensuring data remains up to date as service capacity flexes. • The plan is being developed using current service activity data and projected demand modelling, including cataract treatment volumes and outpatient trajectories. • Regional benchmarking and national variation intelligence are being used to inform future service needs. **2. Capacity and Productivity** • Capacity plans incorporate realistic yet ambitious productivity targets, including improvements in theatre utilisation and outpatient throughput.	April 2026	Associate Director of Planned Care

Recommendation	Management response	Completion date	Responsible officer
• supported by clear delivery actions and milestones. • approved by the Board.	• Initiatives such as the ‘golden patient’ process, interface GP schemes are being scaled to optimise clinical efficiency and the planned insourcing activity with HBSUK. **3. Medium-Term Costing** • Financial modelling has been completed for FY 2025-26, with further costing underway for a three-to-five-year horizon, including sustainability plans for ophthalmology. • Further sustainability plans will be submitted via division by March 2026. **4. Resource Planning** • Workforce plans include confirmed appointments for three ophthalmology consultants (cornea, glaucoma, paediatrics) with start dates through 2026: – Cornea consultant will start 01 September 2025 – Glaucoma consultant has accepted and will start fellowship August 2025 and due to be in post August 2026 – Paediatric consultant has accepted and will start fellowship August 2025 and due to be in post August 2026 • Infrastructure and digital enablers (eg E-consent, clinic room booking, theatre system replacement) are being scoped and procured to support service delivery.		

Recommendation	Management response	Completion date	Responsible officer
	5. Delivery Actions and Milestones • Four key Task and Finish Groups have been established to monitor the workstreams arising from the Eye Care Plan. • The Task and Finish Groups meet monthly, with progress updates provided to the Eye Care Board (ECB) on a quarterly basis. • The Eye Care Working Group and Programme Board have agreed Terms of Reference and are tracking delivery milestones, including pathway redesign and discharge protocols. • Monthly Planned Care Programme Board meetings oversee progress and escalate risks as needed. **Governance and Timelines** The completed draft Eye Care Plan will be further refined and submitted for formal Board approval by April 2026.		
R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery.	The Eye Care Plan has now been approved by the Eye Care Board, which meets bi-monthly to review progress against key workstreams. Updates on performance, risks, and mitigation actions are discussed regularly through this forum, ensuring continuous oversight and alignment with Board governance expectations. Once the Eye Care Plan is approved by the Board, the Health Board will ensure that the Finance and Performance Committee receives updates on delivery at least twice a year. These updates will clearly articulate progress, risks to delivery, and any mitigating actions to support transparency and accountability.	April 2026	Associate Director of Planned Care / Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
	This will be ensured by adding the Eye Care Plan to the Committee's Forward Work Programme.		
R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed.	The Health Board acknowledges the recommendation and is committed to ensuring that risks related to eye care services are appropriately captured and managed within its established governance framework. Ophthalmology risks are managed through the Health Board's Risk Management Framework to support safe, sustainable, and high-quality service delivery. At the operational level, divisional risks – including those related to long waits, workforce shortages, and service pressures – are actively monitored and reviewed through directorate and divisional governance structures to ensure timely mitigation and oversight where required. At the strategic level, there are currently no discrete ophthalmology risks recorded on the corporate or strategic risk registers. Relevant issues are reflected within broader strategic risks, such as recruitment and retention across specialties, the adequacy of strategic planning, and the delivery of planned care waiting list targets, which collectively encompass ophthalmology. Specialty-specific risks are owned and managed at the directorate and divisional level, assessed against the Health Board's approved risk appetite and tolerance. This position will be kept under review, with escalation to a corporate ophthalmology risk if thresholds are met. Oversight is maintained through regular reporting to the Eye Care Board and via Directorate and Divisional Assurance meetings. The Health Board is further strengthening assurance by:	December 2025	Associate Director of Planned Care

Recommendation	Management response	Completion date	Responsible officer
	• Ensuring ophthalmology risks are captured and updated within the relevant risk registers. • Providing regular updates on the delivery of the Eye Care Plan to the Finance and Performance Committee, with clear articulation of risks and mitigating actions. • Drawing on learning from harm reviews and best practice to inform a review of long-waiting patients, overseen by the Planned Care Board.		
R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on: • how patients on the ophthalmology waiting list are managed to prevent harm; • lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and • actual harm caused by ophthalmology waiting delays.	The Health Board acknowledges the recommendation and recognises the need to strengthen assurance on ophthalmology patient safety and waiting list management. The Health Board is committed to ensuring that the Patient Quality, Safety and Outcomes Committee (PQSOC) receives clear assurance on harm prevention, lessons learned, and any actual harm arising from ophthalmology waiting delays. All patient safety incidents in Ophthalmology are assessed via Datix to determine risk and required actions. Any incident resulting in moderate or greater harm triggers a formal harm review, which includes a detailed patient timeline and is assessed using ophthalmology-specific harm criteria. Rapid harm reviews are coordinated by the Quality and Patient Safety (QPS) Team and escalated to the weekly Executive Safety Huddle, ensuring timely oversight and shared learning across the Health Board. Lessons identified from harm reviews are translated into service-level action plans, and shared across the wider clinical team. Thematic	October 2026	Clinical Director for Ophthalmology

Recommendation	Management response	Completion date	Responsible officer
	findings and learning outcomes are reported through Divisional governance, and will form part of the assurance reports to the PQSOC. Through these reports, PQSOC will receive assurance on: The waiting list for initial Ophthalmology appointments is currently being addressed through HBSUK insourcing activity, with the aim of significantly reducing the backlog by the end of the financial year. Early indications show that a good number of patients are being discharged to alternative care pathways, and efforts are being made to target all areas of eye care, noting cataracts are being progressed as part of the regional solution. Additionally, the Patient Initiated Follow-Up (PIFU) initiative is in place as a flexible outpatient care model. This allows eligible patients to arrange hospital appointments themselves when their symptoms worsen, rather than relying on routine scheduling. Together, these activities are part of a broader strategy to minimise harm caused by delays in care and improve patient outcomes. Lessons learned from harm reviews and how they have been applied, through summaries of completed reviews, resulting actions, and thematic learning. Any actual harm arising from ophthalmology waiting delays, via aggregated and case-level data from Datix, rapid harm reviews, and formal investigations coordinated by the QPS team and reported through the established governance pathway. While monitoring and reporting harm remains primarily retrospective and resource intensive, this process provides robust assurance of oversight, learning, and continuous improvement.		

Recommendation	Management response	Completion date	Responsible officer
	Forward-looking actions, including a bespoke review of long-waiting patients (covering Referral to Treatment and Follow-ups), will further inform PQSOC assurance and strengthen governance around ophthalmology waiting list risks.		

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