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Audit Wales

Eye Care Review – Cardiff and Vale University Health Board

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Summary report

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, 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 Cardiff and Vale 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.

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

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

Key messages

Overall conclusion

7 The Health Board is reducing its longest waits, but too many eye care patients are still waiting a long time. While performance against the 'eye-care measure' is above average, it falls well short of the national target, increasing the risk of avoidable harm.

8 The Health Board has taken positive steps to strengthen leadership and address cultural challenges within the ophthalmology service. It has also set up clear processes for identifying, reporting, and learning from harm caused by delays in the ophthalmology waiting list. However, it needs to strengthen long-term planning of eye care services, secure further productivity and efficiency gains and improve Board level oversight.

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 Health Board is acting on immediate service risks but needs a long-term plan to help ensure that eye care services meet both current and future need.

[2] International Organisation of Supreme Audit Institutions

- While the Health Board is taking steps to improve the productivity and efficiency of its eye care services, there is more to do to achieve set targets. For example, targets for theatre optimisation, outpatient modernisation and implementing Getting it Right First-Time recommendations.

Leadership and governance

- The Health Board is strengthening operational and clinical leadership and actively addressing workforce culture challenges.
- Board level oversight of eye care services needs strengthening, by focussing scrutiny on the effectiveness and impact of improvement actions.
- While operational risks are appropriately managed, the corporate risk register does not reflect eye care services challenges, which limits Board visibility.

Ophthalmology performance

- While referral to treatment ophthalmology waits over two years have reduced, the Health Board still has a considerable number of people waiting over one and two years. Over the past two years, the overall number of patients waiting for ophthalmology treatment has risen from around 14,500 to over 16,000.
- The Health Board has consistently failed to meet Welsh Government's eye-care measure target. Most recent nationally reported performance is 65%. While above the Welsh average, it is well below the 95% target.

Managing the risk of harm

- While the Health Board has systems in place to identify, report and learn from harm resulting from ophthalmology waiting list delays, some patients are still experiencing avoidable harm.

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 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**).
Developing a sustainable eye care plan R4 The Health Board should urgently develop an 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 (3-5 year); • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; • supported by clear delivery actions and milestones; • aligned to the emerging Clinical Services Plan; and • approved by the Board (**see paragraph 28**).
Ophthalmology service action plan assurance reporting R5 The Quality Committee and/or the Finance and Performance Committee should receive routine updates on the ophthalmology service action plan, including the impact of actions. The report should include: • a comprehensive overview of current ophthalmology waiting times; • information on avoidable harm suffered by patients because of waiting for treatment; and • an outline of longer-term plans for eye care services (**see paragraph 43**).

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 focusing 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 patient's 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, 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, 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.

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

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 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, 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	2,905	2,764
	North hub	39	26
	Regionally outsourced	750	676
	Total	**3,694**	**3,466**
2024-25	South hub	2,049	1,930
	North hub	950	846
	Regionally outsourced	1,308	1,308
	Total	**4,307**	**4,084**

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 was in March 2023. In March 2023, there were 45,930 patients waiting across the region and this increased to 54,977 by 2025. For cataracts, in March 2023 there were 18,998 patients waiting across the region, this increased to 23,289 by March 2025. Without the regional investments, the position would have been worse, but the regional arrangements are not yet significantly resulting in reduced overall level of ophthalmology waits.

21 In October 2024, Welsh Government awarded the region a further £7.5 million 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 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 eye care 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 is responding to immediate eye care service risks and taking steps to improve productivity and efficiency, but it needs a long-term plan to ensure services can meet both current and future demand.**

Local eye care plans

While there is short term planning focused on immediate risks, it is fragmented and needs to be longer term and joined up.

25 The Health Board has a clear understanding of the barriers to improving its eye care services and is taking action to address them. These include growing service demand, insufficient workforce capacity, inadequate digital and estates infrastructure, issues with ophthalmology follow-up appointments and some workplace cultural issues (which we set out later in this report). However, the Health Board does not have an overarching eye care plan to guide long-term service improvement.

26 Instead, the Health Board has a fragmented planning approach with its eye care priorities articulated in several plans. These include its 2025-26 Annual Plan and an action plan for ophthalmology services. It also has focused plans for implementing the Getting it Right First Time (GIRFT) recommendations and Welsh General Ophthalmic Services pathways, meeting planned care targets, and setting up cataract and glaucoma services at University Hospital Llandough (UHL).

27 The Health Board's action plan for ophthalmology services seeks to address immediate risks identified in the service risk register. The delivery plan is aligned to the National Clinical Strategy for Ophthalmology, mirroring its strategic themes[4]. The plan focuses on areas of highest clinical risk and includes actions such as enhancing cataract surgery facilities and capacity, improving diabetic eye care pathways, increasing diagnostic capacity for glaucoma, and harms reviews for patients with Age-related Macular Degeneration (AMD). However, most of the actions do not have clear delivery timescales or leads.

28 Although these actions may support long-term service improvements, the absence of an overarching eye care plan makes it difficult to clearly understand the Health Board's long-term vision for eye care services. Given ongoing challenges with waiting times, the Health Board must urgently develop a Board-approved, overarching eye care plan to guide sustainable improvements that balance demand to capacity (**Recommendation 4**). This plan should align with the broader Clinical Services Plan, expected to be launched by March 2026, which will set the strategic vision for clinical services over the next decade.

29 In the short term, the Health Board focuses on its demand and capacity, with a focus on what can be realistically delivered. Our 2025 planned care review highlights that demand and capacity modelling for ophthalmology services is improving. However, the overall planning approach remains short-term, often driven by immediate challenges such as long waiting lists or putting in place arrangements to use short-term funding allocations. To inform service planning, a rightsizing exercise is underway to define baselines for workforce, demand,

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

capacity, and value outcomes. The review is being conducted by sub-specialty, starting with Glaucoma.

Plans for improving service efficiency

While the Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, there is more to do.

30 The Health Board is working to improve planned care efficiency and productivity, including ophthalmology. Its planned care programme focuses on key areas such as theatre optimisation and outpatient modernisation. The ophthalmology workstream focuses on transferring services to University Hospital Llandough (UHL), strengthening performance management, and improving quality and patient safety.

31 Focusing on efficiency and productivity is a practical approach which supports service sustainability by optimising the use of existing resources. However, progress is slow. As of August 2025:

- Did Not Attend rates for ophthalmology outpatients was 11.1% for new patients and 11.5% for follow-up patients, exceeding the target of 5% or less;
- only 3.6% of appointments were virtual, against a target of 20%;
- just 0.2% of patients were on See on Symptom pathways, and none were on Patient-Initiated Follow-Up pathways, against a target of 20%;
- theatre utilisation was 73.6%, below the 85% target; and
- 'on-the-day' cancellation rates were 7.5%, missing the target of 2% or less.

32 Our 2025 planned care review highlights limited progress in implementing ophthalmology GIRFT recommendations. The Health Board has recently assessed progress against these recommendations, recognising substantial work remains to fully embed the improvements.

33 The Ministerial Advisory Group on NHS Wales Performance and Productivity has recommended reducing unnecessary differences in waiting times and using best practice in theatre management. One key recommendation is to set up local theatre optimisation boards to improve how theatres are used. This includes following best practice for the number of cases per theatre session. For ophthalmology this means 10 cataract procedures in a 4-hour theatre session, and eight procedures if it is a training session. Currently surgery lists at the new cataract theatre at UHL[5] includes eight per list.

[5] The cataract theatre at University Hospital Llandough opened in July 2025.

Leadership and governance arrangements

34 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.

35 We found that **the Health Board is improving its leadership arrangements for eye care services and is addressing cultural challenges. However, Board level oversight and risk management needs improvement.**

Operational and clinical leadership

The Health Board is strengthening operational and clinical leadership and actively addressing workforce culture challenges.

36 The Health Board has clear leadership and accountability for eye care services, with the Chief Operating Officer overseeing both acute and primary care. Within the Surgery Clinical Board, ophthalmology is led by a triumvirate team comprising a newly appointed Clinical Director, a Directorate Manager, and a Senior Nurse. The leadership team is supported by a band 7 service manager and three band 5 support managers, each responsible for different sub-specialties.

37 The Health Board is actively addressing workforce culture challenges, which stem from years of limited investment, resource constraints, and slow progress in resolving staff-raised service concerns. These issues have contributed to staff disengagement and strained relationships between management and operational teams.

38 In response, the Health Board has strengthened leadership, including restructuring the ophthalmology management team approximately a year ago. It also commissioned the Royal College of Ophthalmology to review its AMD service. While the final report is pending, the Health Board has already accepted the recommendations and made good progress, implementing five of the eight recommendations. This includes the rollout of the Open Eyes electronic patient record across all ophthalmology sub-specialties, improving the efficiency of clinical record-keeping.

39 Executive and operational oversight of ophthalmology performance is generally good. Performance is regularly reviewed through executive performance meetings with the Surgery Clinical Board, as well as routine clinical board and directorate meetings. These meetings typically cover clinical audit, waiting lists, core activity, and clinical validation.

40 However, management oversight tends to mainly focus on reducing waiting times and improving service efficiency. While important this reflects a short-term focus, highlighting the need to balance immediate operational pressures with longer-term planning to develop sustainable eye care services.

Board and committee oversight

Board level oversight of eye care services needs strengthening, with focused scrutiny on the effectiveness and impact of improvement actions.

41 While various committees receive updates, these are often ad-hoc or embedded within broader reports. This makes it difficult to gain a full picture 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 reported separated. The Quality Committee receives various reports where ophthalmology is mentioned such as the Surgery Clinical Board Assurance Report, quality indicators report and Primary Care Eye Health Needs Assessment. Only the Board receives routine updates focused on regional ophthalmology work.

42 However, the Quality Committee received regular updates on the AMD patient harms work, mainly in private sessions. While a public update was provided in April 2025, this was not a standalone report. The update was included within the Surgery Clinical Board Assurance Report.

43 Given the scale of the waiting list and challenges around timely access to care, more regular and focused scrutiny is needed to assess the effectiveness and impact of improvement actions. The Quality Committee and/or Finance and Performance Committee should receive assurance on progress against the ophthalmology service action plan and the impact of these actions (**Recommendation 5**).

Risk management arrangements

While operational risks are appropriately managed, the corporate risk register does not reflect eye care services challenges, limiting Board visibility.

44 The Health Board's ophthalmology department and Surgery Clinical Board risk registers appropriately capture key operational risks. These include long waits for new and follow-up appointments, adverse media coverage, and delays in wet AMD treatment due to clinical staffing shortages. While these risks are regularly reviewed at departmental and clinical board levels, some have remained on the register for a number of years, suggesting limited impact from mitigating actions.

45 At Board level, the corporate risk register does not include a risk for ophthalmology, which is unexpected given the volume of patients waiting and the potential risk of harm. This suggests that some high-risk operational issues may not be escalated appropriately, and that ophthalmology-related risks are not currently visible at Board level. Our 2025 planned care review also recommended strengthening risk management at a planned care programme level.

Ophthalmology performance

46 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 times. 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.

47 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**.

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

Performance against Welsh Government planned care targets

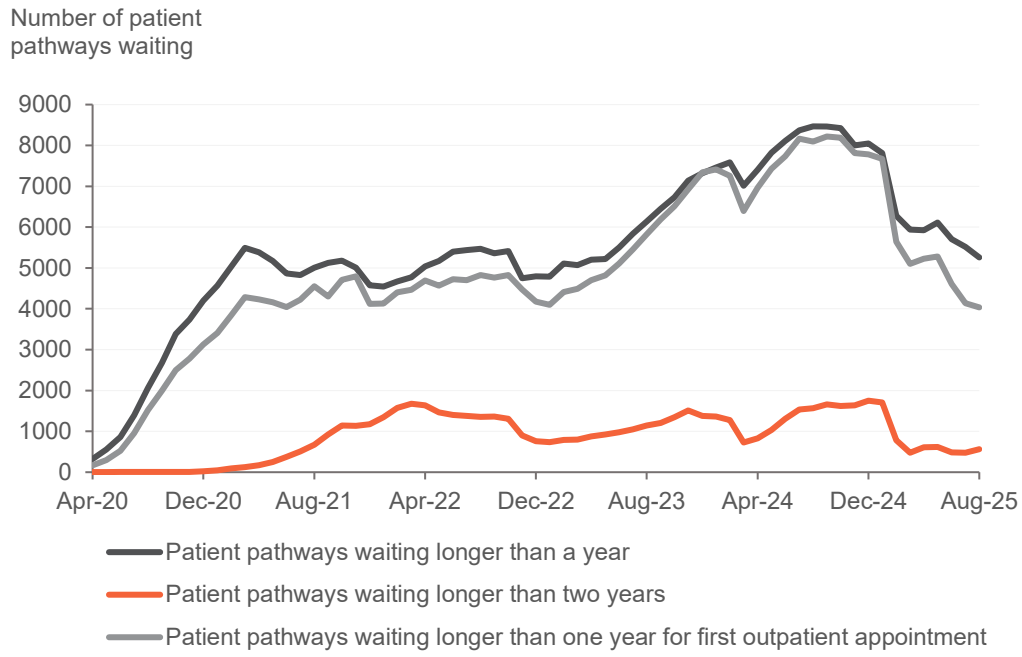
While the Health Board has reduced its longest 'two-year' waits, it still has a large number of eye care patients waiting a long time.

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

- 5,255 patients waiting longer than a year on the ophthalmology waiting list;
- 4,036 patients waiting longer than one year for their first ophthalmology outpatient appointment; and
- 566 patients waiting longer than two years on the ophthalmology waiting list.

50 Performance across all three measures has worsened since the pandemic. There has been some improvement from January 2025 onwards, especially in relation to reducing waits over two-years. However, the improvements coincide with further additional Welsh Government non-recurrent funding to address long cataract waits. Over the past two years, the overall number of patients waiting for ophthalmology treatment has risen from around 14,500 to over 16,000. This growth alongside the long-term trends identified in **Exhibit 3** suggest that the Health Board needs a sustainable solution to address both long waits, and the overall level of waits.

Exhibit 3: the number of ophthalmology patients waiting longer than one and two years, Cardiff and Vale University Health Board



Source: Referral to treatment times, Welsh Government

Eyecare measure waiting list performance

Despite above average performance, the Health Board has consistently failed to meet Welsh Government's eye-care measure target, falling well short of the 95% target.

51 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)[6] waits 25% longer than the clinically assessed target date, then it counts as a breach.

[6] 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.

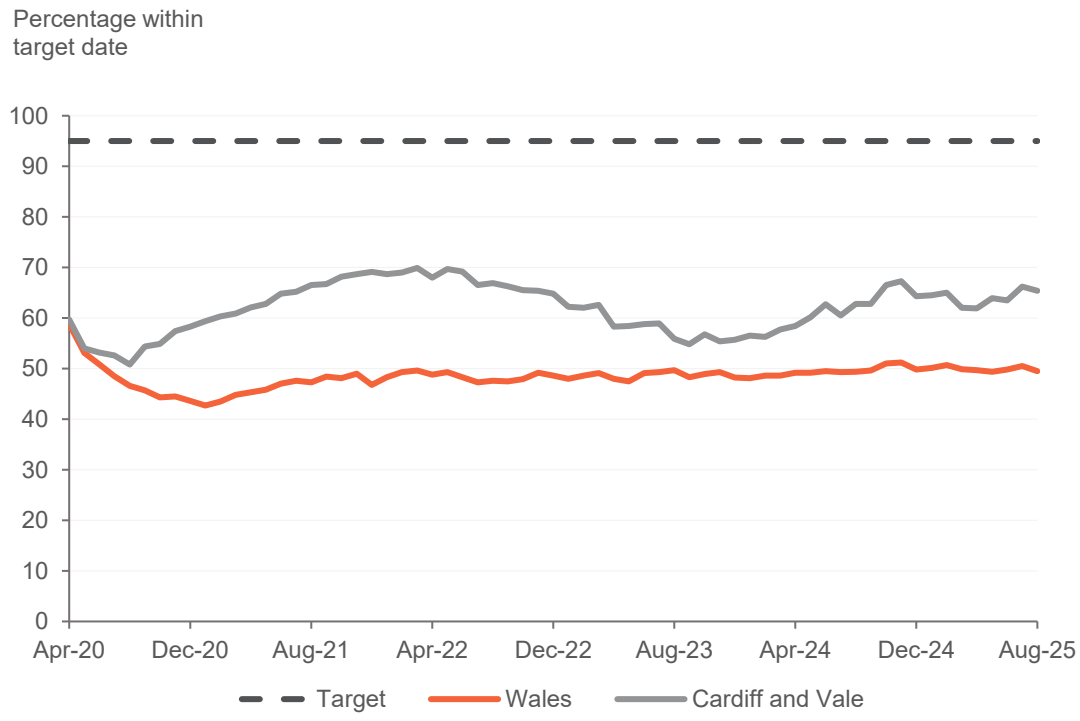
Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in four weeks. Mrs Jones waits just over six weeks – therefore the target has been breached. Within five weeks, this would not have been a breach.

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

52 **Exhibit 5** shows performance against the Welsh Government eye care measure target. While the Health Board consistently performs above the Welsh average, it has never met the national target of 95%. In August 2025, performance was 65%. Patients identified as Health Risk Factor R1 have an increased potential risk of harm and permanent sight loss. 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.

Exhibit 5: Percentage of Health Risk Factor (R1) patients waiting within their target date or within 25% beyond, Cardiff and Vale University Health Board



Source: Eye Care Measure performance, Welsh Government

Managing the risk of harm

53 Until the Health Board can sustainably manage its ophthalmology waiting lists, referral to treatment and eye care measure performance remains a significant concern. This will likely continue placing some patients at greater risk of avoidable harm and irreversible sight loss. Patients' eye conditions may deteriorate while waiting, causing pain, anxiety, affect 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.

54 We found that **while the Health Board has clear processes to identify, report and learn from harm resulting from ophthalmology waiting list delays, some patients are still experiencing avoidable harm.**

55 The Health Board has a clear and well-documented harms review process, aligned with Royal College of Ophthalmologists guidance. The process considers both clinical harm and broader impacts on patients' quality of life, such as loss of independence or income. The service has a post dedicated to ophthalmology harm reviews. DATIX records and waiting list validation are used to identify potential harm. The reviews focus on AMD, and more recently, glaucoma patients lost to follow-up[7]. Moderate and serious incidents are reviewed by a Harms Panel, with Duty of Candour and Welsh Government's serious incidents process applied where appropriate. Findings are recorded in a harms database, and patient safety learning reviews support ongoing improvement.

56 The Quality Committee receives regular updates on harms for AMD patients lost to follow-up (**paragraph 42**). Key issues identified included inconsistent approaches to documentation, variation in procedures and data collation issues resulting in patients being lost to follow-up. While not identifying the number of patients coming to harm, the April 2025 committee update demonstrated how lessons have been learnt (see **Recommendation 5**). The Health Board has taken action to improve processes, for example by developing a standard operating procedure for AMD patients and implementing the Open Eyes patient record across all ophthalmology specialties.

[7] Lost to follow-up describes patients who missed follow-up care, often because of administrative or system issues.

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: • 2024-25 and 2025-26 Annual Plans • Local eye care plans delivery/implementation plans and progress reports. • Health Board GIRFT review and update reports • Board papers • Quality Committee papers • Finance and Performance Committee papers • Operational risk register(s) for eye care services. • Corporate Risk Register and Board Assurance Framework • Ophthalmology Harms Standard Operating Procedure • Documentation on the use of Welsh Government funding • Regional Ophthalmology Strategy, associated programme management documentation and progress reports • Regional ophthalmology financial plans • Regional cataracts plan • Regional Demand and Capacity planning
Interviews	We interviewed the following: • Chief Operating Officer • Medical Director, Surgery Clinical Board • Director of Nursing, Surgery Clinical Board • Ophthalmology Directorate Manager • Ophthalmology Clinical Director • Senior Nurse, Surgery Clinical Board • Lead Glaucoma Optometrist • Primary Care Lead Optometrist • Ophthalmology Harms Lead • Senior Programme Manager, South East Wales Regional Ophthalmology Programme

Element of audit methods	Description
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 seek 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 (3-5 year). • The plan is deliverable within the resources available to the Health Board.
	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

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
		(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.
	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.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
		• 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. – 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. • 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 25/26, with appropriate phasing and timeframes assigned to programme priorities	March 2026	Chair of Regional Ophthalmology Programme Board
R4 The Health Board should urgently develop an 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 (3-5 year); • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models; • supported by clear delivery actions and milestones; • aligned to the emerging Clinical Services Plan; and • approved by the Board.	The ophthalmology improvement plan is in progress, the plan requires a number of external streams to feed into the plan in order to include timelines and costings from capital project groups, regional plans, digital plans and primary care pathway rollouts and scaling. This will also be fed by the clinical services plan and feed into the Health Board IMPT.	March 2026	General Manager and Clinical Director for Ophthalmology

Recommendation	Management response	Completion date	Responsible officer
The Quality Committee and/or the Finance and Performance Committee should receive routine updates on the ophthalmology service action plan, including the impact of actions. The report should include: • a comprehensive overview of current ophthalmology waiting times; • information on avoidable harm suffered by patients because of waiting for treatment; and • an outline of longer-term plans for eye care services.	All committees will be fed by Ophthalmology plans to include Finance, Performance and quality. A regular update is provided on Harm, performance and finance upward through Senior Management Team.	February 2026	General Manager and Clinical Director for Ophthalmology

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