

## **Agenda – Health and Social Care Committee**

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Meeting Venue:	For further information contact:
Hybrid – Committee Room 5, Ty Hywel and video conference via Zoom	Sarah Beasley Committee Clerk
Meeting date: 20 March 2025	0300 200 6565
Meeting time: 09.00	<a href="mailto:SeneddHealth@senedd.wales">SeneddHealth@senedd.wales</a>

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**At its meeting on 5 March, the Committee agreed a motion under Standing Order 17.42 (ix) to exclude the public from item 1 of today's meeting**

### **Private pre-meeting**

(09.00–09.30)

#### **1 NHS waiting times monitoring report**

(9.00–9.30)

(Pages 1 – 24)

Paper 1 – NHS waiting times monitoring report

### **Public meeting**

(9.30–14.40)

#### **2 Introductions, apologies, substitutions, and declarations of interest**

(09.30)

#### **3 Ophthalmology Services in Wales: evidence sessions – Panel 1**

(9.30–10.30)

(Pages 25 – 54)

Rhianon Reynolds, National Clinical Lead for Ophthalmology, Clinical

Implementation Network – NHS Executive

Consultant Ophthalmologist and Clinical Director, Aneurin Bevan University  
Health Board

Llywydd of the Royal College of Ophthalmologists in Wales



William Oliver, Ophthalmology Clinical Implementation Network for Planned Care – NHS Wales Executive

Research brief

[The National Clinical Strategy for Ophthalmology](#)

Paper 2 – The Royal College of Ophthalmologists – Consultation response

## **Break**

(10.30–10.45)

### **4 Ophthalmology Services in Wales: evidence sessions – Panel 2**

(10.45–11.45)

(Pages 55 – 57)

Dr Andrew Pyott – Consultant Ophthalmologist, Clinical Lead –  
Ophthalmology – NHS Highland

Paper 3 – Briefing paper: Dr Andrew Pyott, Consultant Ophthalmologist and  
Clinical Lead in Ophthalmology

## **Lunch**

(11.45–12.30)

### **5 Ophthalmology Services in Wales: evidence sessions – Panel 3**

(12.30–13.30)

(Pages 58 – 61)

Owain Mealing, Chair – Optometry Wales

Dan McGhee, Non-executive director – Federation of Optometrists and  
Dispensing Opticians

Dr Peter Hampson, Clinical and Policy Director – Association of Optometrists

Paper 4 – Optometry Wales: consultation response

## **Break**

(13.30–13.40)

## **6 Ophthalmology Services on Wales: evidence sessions – Panel 4**

(13.40–14.40)

(Pages 62 – 69)

Owen Williams, Director – Wales Council of the Blind

Ffion Haf Lewis, RNIB Cymru

Sara Crowley, RNIB Cymru

Marian Williams, Macular Society

Lowri Bartrum, Vision Support

Paper 5 – RNIB Cymru: consultation response

## **7 Paper(s) to note**

(14.40)

### **7.1 Letter to the Minister for Mental Health and Wellbeing following the Committee's scrutiny session on the Welsh Government's draft budget**

(Pages 70 – 71)

### **7.2 Letter from the Minister for Mental Health and Wellbeing in response to follow up questions from the Committee's scrutiny session on Welsh Government's draft budget**

(Pages 72 – 74)

### **7.3 Letter from Chair of Petitions Committee re Petition P-06-1488: Establish a 'Care Society' to Tackle the Long COVID Crisis in Wales**

(Pages 75 – 76)

## **8 Motion under Standing Order 17.42 (ix) to resolve to exclude the public from the remainder of today's meeting**

(14.40)

## **Private meeting**

(14.40–15.00)

## **9 Ophthalmology Services in Wales: consideration of evidence**

(14.40–15.00)

# Agenda Item 1

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# Agenda Item 3

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# Inquiry into Ophthalmology services in Wales

March 2025

Half of the highest risk eye patients (those at risk of irreversible harm if they miss their target date for an outpatient appointment) on ophthalmology waiting lists in Wales [have already waited at least 25% beyond their target date](#).

This is very concerning, given for patients with conditions such as glaucoma and age-related macular degeneration these long waits are likely to lead to irreversible sight loss. Demand is set to grow further in the coming years. Our [cross sector Eye Care Data Hub](#) shows that in Wales the prevalence of primary open-angle glaucoma is projected to increase by 16% over the next decade, while there will be a 23% jump in the prevalence of neovascular age-related macular degeneration.

Clearly urgent action is needed to address this situation. [The National Clinical Strategy for Ophthalmology](#), commissioned by the Welsh Government and NHS Wales and published in September 2024, provides a comprehensive analysis of the challenges facing ophthalmology services. Most importantly, it lays out what needs to happen next to put integrated eye care services on a sustainable footing. The Royal College of Ophthalmologists fully endorses the conclusions of the Strategy, and the need to adequately resource the Ophthalmology Clinical Implementation Network in the coming months and years to deliver it.

Our response to this inquiry highlights the three key enablers to improving eye care services in Wales – digital transformation, improving estates to facilitate regionalised care, and putting in place the workforce to meet demand.

## 1. Digital transformation

A [2024 Royal College of Ophthalmologists survey of clinical leads](#) found that no ophthalmology department in Wales had a well-functioning electronic patient record (EPR) system, interoperable patient records with optometry, nor an electronic eye care referral system.

These are all serious blockers to the delivery of more efficient integrated services, and the delivery of care closer to people's homes as envisaged by WGOS reforms.

The roll out of an ophthalmology specific national EPR system, accessible in both primary eye care services and hospital eye services, is essential and long overdue. This will need investment and leadership from the Welsh Government to facilitate Digital Health and Care Wales and health boards implementing the ophthalmology EPR at pace.

Likewise, an electronic referral system between primary and secondary eye care is needed to deliver more efficient care and bring down waiting lists. Both of these solutions were identified as long ago as [a 2016 review undertaken by Healthcare Inspectorate Wales](#), but frustratingly little progress has been made since then.

## 2. Improved estates to facilitate regionalised care

The capacity of ophthalmology estates to properly meet demand is a UK-wide problem. In our 2024 survey of ophthalmology clinical leads, sufficient clinic space was the joint most cited factor that would improve patient services.

We know however that Wales has particularly severe challenges with both the capacity and condition of its estates. One unit has highlighted a lack of ultrasound or pan-retinal photocoagulation laser and microscopes operating at the end of life.

The National Clinical Strategy for Ophthalmology (NCSOphth) also found that *'CAVUHB have regular problems with leaks from toilets above into clinical areas, and ABUHB had to stop all activity in 2023 when there was a roof collapse due to a faulty overflow pipe. BCUHB ophthalmology has ivy growing through walls and a roof that requires buckets when it rains. Patched floors create an unsafe environment for those with visual impairment to navigate, creating accessibility issues for the people most in need of our help'*.

The NCSOphth rightly advocates that this needs a fundamental rethink of how care is delivered in Wales, with complex care undertaken at central sites with more routine care in local hospital eye services supported by primary and community eye care services. This will require investment in all sites, with central hubs 'large enough to accommodate need, at the forefront of technology and advanced clinical care with enough space to train medical and nonmedical colleagues and to allow predicted expansion of demand'.

## 3. The workforce in place to meet demand

Addressing the challenges faced by NHS estates can also facilitate another key enabler for improving services – having sufficient workforce in place to meet rising demand.

In recent years enhanced optometry services have developed which mean more care can be delivered in this setting which would previously have been referred into hospital eye services. This is a positive shift, embedded in the new 2023 optometry contract. This will mean patients at the lowest risk of vision loss, that still need ongoing care, receive care closer to home.

Unfortunately those at much higher risk of sight loss and requiring more complex care will need treatment in the hospital eye service, overseen by consultant ophthalmologists.

Wales has much lower number numbers of consultant ophthalmologists per population head than most of the rest of the UK. Wales has 1.97 ophthalmologists per 100,000 population, far below our minimum recommended ratio of 3 to 100,000 to deliver effective hospital eye services. Many sites, particularly in West Wales, face significant recruitment and retention issues. This is leading to an increasing reliance on locums to fill gaps.

As a move towards sustainably filling these shortages, [we recommend a phased approach to increasing ophthalmology specialty training places](#) – with an additional 36 places by 2031.

We also recommend that the Welsh Government adopts a granular approach to workforce planning, taking into account prevalence data for all eye conditions and the optimum workforce team needed to manage care. The Royal College of Ophthalmologists has begun to undertake this work for each sub-specialty through expert working groups, captured on an ongoing basis in [this online resource](#). This shows, for example, that for glaucoma care we need at least 0.6 glaucoma teams (1 consultant, 2 resident doctors, 1 optometrist, 1 nurse) per 100,000 population head. This would require a minimum of 19 glaucoma teams in Wales.

The Royal College of Ophthalmologists looks forward to working with policymakers in Wales to ensure we have the right workforce in place to meet demand for eye care services, alongside tackling the other key challenges identified in this response.

# Agenda Item 4

Senedd Hearing 20th March 2025  
Briefing Notes

In September 2021 a document entitled "[External Review of Eye Care Services in Wales](#)" was published and this would be a useful starting point for any discussion. In particular, the ten recommendations made then, would merit investigation as to what extent they have been fulfilled.

Scotland is a country of similar size and faces some of the geographical and other challenges experienced in Wales.

It may be useful to discuss areas where another devolved Health Department (with similar funding arrangements) have been able to make changes.

There are some aspects which might merit comparisons between the two nations.

## 1/ OpenEyes

There is now a planned roll out of this electronic system throughout the country. Greater Glasgow and Clyde have been the first Health Board to fully adopt this EPR (electronic patient record), and they now have no paper notes.

## 2/ NESGAT (NHS Education for Scotland Glaucoma Award Training)

As mentioned in the report, Scotland has a higher number of Independent Prescribing Optometrists than other parts of the UK. Those with specific training in the management of Glaucoma can now manage patients whom the Hospital Eye Service (HES) deem stable. These patients are discharged from HES until such time as a re-referral is deemed necessary. This scheme is being rolled under around the country.

## 3/ Cataract services.

It was previously reported the average number of cataract surgeries performed in a 3.5 hour session in Scotland was 5.6. There is impetus for each unit in the country to

regard that one cataract operation every 30 mins (cataract only lists) is the absolute minimum. This should be irrespective of training or "service only". More units are now using Immediate Sequential Bilateral Cataract Surgery (ISBCS) as a means of encouraging theatre efficiency, with residents being exposed to the technique.

There is also the development of High-volume cataract surgery training being proposed for residents. Currently, the only venue is the Golden Jubilee National Hospital, Clydebank. In a six-month period, a senior resident might expect to perform 300 to 400 surgeries and a junior 100-150. It is proposed to make this experience available to more surgeons in training at other sites around the country.

The harsh fiscal environment has led to the cancellation of several of the planned Elective Care Centres, but the National Treatment Centre Highland (NTCH) was opened in March 2023 and now accepts patients from other parts of the country. This is proving an effective way of tackling very long waits for treatment. The NTCH has met the minimum requirement of 7 on a (cataract only) list for all surgeons, and several surgeons regularly achieve more than this.

Throughout the country there is patchy engagement with improving theatre efficiency. It is not always straight-forward to identify the impediments, but frequently there can be perverse disincentives for the nursing staff, especially when they do not work in dedicated ophthalmic teams.

Scotland does not yet have the serious competition brought about by using the Independent Sector to bring down waiting times that has been experienced in England. (Over 50% NHS Cataract surgery in England performed by Independent Providers). However, quite a number of Health Boards have been inviting the independent sector to use theatres at weekends, often with contracts that insist on higher numbers than are the norm for standard NHS lists during the week.

Like some units in Wales, there are some departments where theatre efficiency is compromised by Intra-vitreal injections (IVT) being performed in theatre rather than a clean room in the Out-patient department (OPD).

#### 4/ Other long-term conditions

It is always dangerous to equate Ophthalmology with "Cataract surgery". There are justifiable concerns about the long waits for what should be a quick and reliable procedure to reverse sight loss. However, even more urgent are those return patients with long term conditions for whom treatment is more time limited. If a Macula service is not able to treat patients in a timely manner, then not only might the individual be exposed to the risk of irreversible sight loss, but the Health Board may have been wasting expensive treatments for poor gain. Some treatments require to be given at the correct dosing interval or not at all.

The Economics of the use of biosimilars or novel treatments with extended dosing intervals may need to be discussed.

5/ Estate

At the time of the 2021 Report significant concerns were raised regarding the Estate across many of the Welsh Health Boards.

6/ Vitreo-retinal (VR) services.

The 2021 Report also raised concerns regarding cross-border patient flows and a lack of long-term resilience in the Welsh VR provision.

Andrew Pyott

12/03/2025

# Agenda Item 5



Optometry Wales  
Optometreg Cymru

## **Optometry Wales Written Response to the Health & Social Care Committee's short inquiry into Ophthalmology Services in Wales.**

Optometry Wales is the umbrella professional body for all community optometrists, dispensing opticians and optometric practices in Wales with our main function to represent the profession at all levels in Wales. Optometry Wales negotiates on behalf of the statutory bodies (the Regional Optical Committees) with Welsh Government and NHS Wales in respect of national NHS services provided by optometry in primary care.

Optometry Wales is pleased to be invited to both attend to provide oral representation and a written response to the Health and Social Care Committee inquiry into Ophthalmology.

### **1. Organisational reform and service efficiency**

In October 2023, Welsh Government advanced the integration of primary and community care optometrists through Optometry Contract Reform under Wales General Ophthalmic Services (WGOS) consisting of five levels of service. Initial integration of services which led to the shift of services from secondary care to optometry commenced in 2003 with PEARS (Primary Eyecare Assessment and Referral service), 2004 with Low Vision Service Wales and in 2013 with the Eye Health Examination Wales Service. Welsh Government (WG) policy documents<sup>1,2,3,4</sup> have supported this shift of services from secondary care to primary care optometry. The policy direction of WG to support health board optometric advisers and health board hosted Eye Care Collaborative Groups has ensured that the shift of services can be supported via a shared collaboration between optometry and ophthalmology. The aim of the integrated eye care pathways is to reduce the number of referrals into hospital eye departments by 1/3 (referral filtering), and to increase capacity in hospital departments by freeing up 35,000 follow up appointments through monitoring, management and treatment in primary care. Optometry practices across Wales have fully embraced the change and the move to a more clinical focus with many clinicians undertaking additional training to upskill in the required qualifications.

The new Independent Prescribing Service (WGOS5) has had time to embed across Wales with significant patient numbers (over 2000/ month across 90+ practices, with the highest number of service delivery being seen in February claim data of nearly 3000 patients supported) being seen in primary care that would traditionally have been seen in Eye Casualty hospital clinics and with more optometrists qualifying as independent prescribers in Wales on a monthly basis this is expected to continue.

WGOS4 (Glaucoma, Medical Retina and Hydroxychloroquine) services are in the process of being rolled out across Wales and are not yet fully embedded. The Health Boards that previously had local services prior to contract reform which have transitioned to the new

services have been faster to implement the new services, but all 7 Health Boards have now commenced at least one of the patient pathways. However, patient numbers are starting to increase with a doubling of service delivery seen in the February 2025 claim data in comparison to January 2025 (800 WGOS4 services provided in comparison to 419). 73 practices across Wales are now listed to deliver these services with more practices due to join WGOS4 once all health boards have established all elements of the service and further optometrists are undergoing training across Wales to also undertake the services.

## **2. Workforce expansion and training:**

As part of 2023 Optometry Contract Reform, WG has introduced a Quality For Optometry mandatory contract requirement for all optometry practices. From January 2025, this requires all optometry practices to submit monthly workforce data which includes their skillset and higher qualifications. This data will be crucial to identify any workforce shortages to then support targeted interventions whether for increasing in a particular qualification or in a specific geographic area.

During the recent contract negotiations Optometry Wales proposed the establishment of an optometry workforce group which was agreed to be taken forward although has not yet commenced. Optometry Wales would like to see that workforce group taking a holistic approach to the review of workforce for both optometrists and dispensing opticians from the point of entry to training (and recruitment) including at undergraduate level through to higher qualifications in Independent Prescribing, Glaucoma, Medical Retina and Low Vision, with a need to map the (current and future) demand for primary care optometry services against current workforce and against all areas of Wales.

Welsh Government have supported the upskilling of optometrists and dispensing opticians via funding provided to Health Education and Improvement Wales to obtain higher qualifications in Independent Prescribing, Glaucoma, Medical Retina and Low Vision. Optometry practices, clusters and health boards have also provided funding for these higher qualifications.

Welsh Government have supported the establishment of three teach and Treat Centres in North, West and South Wales. This ensures that clinical placements required for many of the higher qualifications can be accessed by all practitioners in a timely manner, delays have however meant that North Wales Teach and Treat clinic only came on line in the latter part of 2024. In addition, WG have supported HEIW to establish Advanced Training Practices which fund appropriately skilled optometrists to host a clinical placement within their own practice to further enhance placement capacity. WG are funding practices who release practitioners to complete glaucoma clinical placements for time taken out of practice. WG is the only UK government to support optometrists and dispensing opticians with a tiered level of remuneration for continuing professional development grants based on their use of higher qualifications within WGOS.

### **3. Hospital and infrastructure improvements:**

Optometry Wales Board is frustrated with the delays of implementation of the ophthalmic electronic patient record (EPR) and eye care referral system (ERS). The lack of a shared care ophthalmic EPR and digital eye care referral solution is adding an administrative burden to both optometry and ophthalmology as onerous administration is required to accommodate referrals from optometry to ophthalmology and to discharge secondary care patients from ophthalmology to optometry. This administrative burden means that there is double keying of data for optometry practitioners which reduces clinical capacity to see more patients and support with the reduction of ophthalmology waiting lists. Optometry Wales has been working with WG, DHCW and NHS Wales to support in whatever means possible to overcome the challenges involved with delivery of an ophthalmic EPR and electronic referral solution.

### **4. Clinical Networks and equal access to care:**

Optometry Wales is a member of the Ophthalmology Clinical Implementation Network (CIN) which brings together all stakeholders including third-sector organisations to discuss and agree ways to ensure equal care across regions, addressing disparities in care delivery and waiting time performance. In each of the Health Boards Eye Care Collaborative Groups (ECCGs) have been established with both primary and secondary care inclusion to ensure sharing of information, frequency of ECCG meeting is variable across the Health Boards.

Health Boards also report progress of Optometry contract reform implementation via a national reporting template and share best practice with all groups. This common sharing of WGOS data alongside ophthalmology waiting time data supports the assessment of new optometry care pathways alongside the data that is collated from the payment/audit WGOS claim forms. Data relating to the number of patients seen under WGOS alongside the number of patients discharged from ophthalmology to WGOS supports the assessment of the effectiveness of new care pathways. NHS Wales Shared Services Partnership has committed to the introduction of a national dashboard to share this data with key stakeholders.

### **5. Oversight and implementation:**

Optometry Wales Board is frustrated with the delays of implementation of digital strategies within eyecare with a significant amount of clinician time being taken up by administrative workload. Lack of digital solutions is hindering health boards in discharging patients to optometry as a paper exercise is required rather than optometry being able to access a patient digital record. Optometry Wales awaits a further update from DHCW on next steps to progress the digital solutions that are essential to support the transformation in eye care, reduce ophthalmology waiting lists and thus reduce the risk of irreversible sight loss.

## References

1. [Together for Health:Eye health care delivery plan\(2013-2018\) Annual report 2014 english](#)
2. [Well-being of Future Generations \(Wales\) Act 2015: the essentials \[HTML\] | GOV.WALES](#)
3. [A healthier Wales: long term plan for health and social care | GOV.WALES](#)
4. [NHS Wales eye health care: future approach for optometry services | GOV.WALES](#)

# Agenda Item 6

**R N I B**

Cymru

Golwg gwahanol

See differently

## **RNIB Cymru briefing for Senedd Cymru Health and Social Care Committee Ophthalmology Inquiry**

**Contact:** [REDACTED]

### **Eye Watering: ophthalmology waiting lists in Wales**

More than **80,000 patients** at the **greatest risk of permanent sight loss** are waiting too long for sight saving treatments – more than enough to fill the Principality Stadium to capacity.

The number of ophthalmology patients waiting beyond their target date has **more than doubled** in the past five years. The [former President of the Royal College of Ophthalmologists in Wales](#) has warned of a “tidal wave of blindness across the whole country”, the consequences of which would be “catastrophic” if services are not reformed.

Sadly, for many who do lose some or all their sight, this could have been avoided if they were seen on time. We hear from grandparents who’ve lost so much sight while on a waiting list that they never saw the faces of their newborn grandchildren. People waiting for treatment have lost their jobs, which depended on them being able to drive, which they could no longer safely do. What makes this truly heartbreaking is the knowledge that things could have been so different if only they had received the right care and treatment at the right time.

## **Rising demand for eye care services**

Half of all sight loss is avoidable with early detection and treatment. But the prevalence of eye diseases like glaucoma and age-related macular degeneration increases as our population grows older. [One in five people](#) will live with permanent sight loss in their lifetime and demand for eye care services is expected to [rise by as much as 40 per cent](#) over the next 20 years.

Ophthalmology services in Wales are already under immense pressure. Ophthalmology is the busiest outpatient specialism in the Welsh NHS, accounting for [one in every seven](#) patients on the waiting list.

The number of patients waiting for an ophthalmology appointment increased by [169 percent in the past decade](#). Wales has the lowest numbers of Consultant Ophthalmologists per capita of any of the UK nations and in Europe [only North Macedonia has fewer](#).

## **The National Clinical Strategy for Ophthalmology**

In September 2024, the NHS Wales Executive published its clinically-led blueprint for reforming ophthalmology services across Wales, the [National Clinical Strategy for Ophthalmology](#).

Among the strategy's key recommendations is a fundamental redesign of the delivery model of eye care centered around three purpose-built regional centres of excellence which would enable services to attract and retain qualified staff, and allow for ophthalmic capacity, expertise, and technologies to be pooled to ensure an efficient and sustainable service. The Royal College of Ophthalmologists in Wales [described the move to a regional model](#) as 'vital for survival of ophthalmic care in Wales'. In the short term, the strategy calls on health boards to align governance finance and priorities to a regional delivery model agree a regional ophthalmology budget which is ringfenced and pooled with a central finance governance not dependent on individual Health Board constraints.

The Cabinet Secretary published a [written statement](#) in December outlining his support for the strategy and his expectations for progress to be made towards its implementation. Whilst this is a positive step, there have been no deadlines put in place and no additional funding allocation to deliver the reforms. It remains unclear who is responsible for coordinating and monitoring the shift to a regional delivery model and whether health boards have dedicated resources responsible for taking this forward.

## **Delays to digitisation**

An electronic patient record and referral system (EPR) which intended to give hospital ophthalmologists and community optometrists access to shared clinical information to monitor eye health and provide shared care was [launched in 2021](#). Four years later, the system is still not operational in any health boards in Wales and does not fulfill most of the core functions it was intended to.

The National Clinical Strategy for Ophthalmology notes the “considerable frustration around the lack of EPR and referral systems” and urges Welsh Government to prioritise and fast track the implementation of an EPR via Digital Health and Care Wales with the sufficient resources, clinical leadership, functionality and data interconnectivity across Wales to support the ambitions of this strategy and to ensure seamless movement of patients and clinical information between community and hospital services. In addition, a complete digital strategy for eye care needs to be developed to ensure services are optimised.

To date, there has been no public ministerial commitment to commission the digital strategy and there is no roadmap in place for the implementation of EPR.

## **Key points for the inquiry to consider**

It has been four years since [an External Review of Eye Care Services in Wales](#) described the staffing situation facing Wales' eye care services as “extremely serious” and “very fragile”.

The National Clinical Strategy provides the blueprint for a modern eye care system that is capable of meeting rising demand and able to deliver care to patients at the right place and at the right time. The [ophthalmology clinical sector has warned](#) that “inaction risks the collapse of eyecare services in Wales” and described the National Clinical Strategy as “the last chance we have to plan a viable future for eyecare in Wales.”

To date, there has been no commitment from the Welsh Government to make significant investments needed to implement the recommendations of the National Clinical Strategy. Without this, Wales' eye care waiting lists will continue to rise as will the number of patients who are needlessly losing their sight while waiting for NHS treatment.

The Welsh Government must commit the necessary resources to facilitate the shift to a sustainable regional delivery model. Health boards will not be likely to commit to a fundamental reorganisation of services without appropriate incentives, resources and ministerial direction. Currently, there is no incentive for a well performing health board to pool resources with an under-resourced or poorly performing health boards nearby. This hinders the shift to a regional model of delivery which the entire eye care sector in Wales agrees is the only viable future for the service. The Welsh Government must set clear expectations, including milestones and targets for implementation of the National Clinical Strategy. It must also equip the NHS Executive with the resources and powers it needs to drive operational change before we will begin to see progress towards a regional delivery model.

In addition, there is a considerable disparity between the number of people waiting beyond their target date and the number that are reported as

having suffered harm as a result. In the absence of Standard Operating Procedures that would apply in the event of an unexpected death in other clinical specialties as a result of a treatment delay, ophthalmology relies on the reporting of patient safety incidents through the DATIX system.

RNIB Cymru's 2023 Freedom of Information Request to Public Health Wales (FOI 2023 147) revealed that between June 2021, when 64,790 patient pathways were beyond their target date, and September 2023, when the figure was 77,230 patient pathways, only 45 patient safety incidents were reported across Wales relating to ophthalmic services.

This is almost certainly a significant underreporting of the scale of harm befalling patients and clearly shows that the system is not working. It is critically important that services accurately quantify the numbers of patients who have lost sight as a consequence of delayed treatment.

If incidents of harm are not reported then they are not investigated, remedial action is not taken, improvements are not identified, and learning is not embedded to prevent similar incidents occurring in the future. Equally, decision makers, including Health Board leaders, the NHS Executive, the Cabinet Secretary for Health and Social Services and the Senedd Health and Social Care Committee have no insight into the scale of real harm that is being experienced by eye care patients and are therefore unable to make fully informed decisions about where to focus resource and attention to improve patient safety.

The Welsh Government must improve the accurate reporting of the harm caused by delays to diagnosis and treatment so that eye care is afforded appropriate priority alongside other long-term chronic conditions.

While we wait and hope for a commitment and investment from the Welsh Government to support these plans to improve our eye care services, more than 80,000 people are sitting at home, anxiously awaiting their fate, hoping for an eye clinic appointment that could save their sight.

## Background

In 2019 the Welsh Government introduced the [Eye Care Measures for NHS Outpatients](#) (Eye Care Measures) after concerns were raised by RNIB Cymru in its report “Real Patients Coming to Real Harm” that ophthalmology services across Wales were struggling to manage key issues around capacity and demand. Patients were waiting far too long for both first ophthalmology appointments and for follow-up appointments but, because referral to treatment time targets focuses attention exclusively on new patients, those already in the system and in need of ongoing monitoring and treatment were deprioritized, regardless of clinical risk. This caused significant numbers of patients with treatable conditions to permanently lose their sight.

Wales was the first country in the UK to introduce these dedicated clinical prioritisation targets for ophthalmology. Introduction of the Eye Care Measures aimed to shift the focus away from traditional referral to treatment targets in favour of a more prudent approach to waiting list management and clinical prioritisation. Unlike referral to treatment time targets, the Eye Care Measures allow for clinical capacity to be directed to the most urgent cases to ensure that patients with the highest levels of risk associated with their condition are treated in a safe and clinically appropriate timeframe.

This is critical for ophthalmology because a significant number of patients need to be seen much sooner than the 26-week referral to treatment target to mitigate the risk of irreversible harm or blindness. Many also require follow up outpatient treatments at regular intervals.

Under the Eye Care Measures, all new and follow-up patients are categorised based on their clinical need and given an individualised target date for when they should be seen.

Due to the significance of the consequences of delayed treatment health board targets are for 95 percent of highest risk patients to be seen within their clinical waiting time. Each of these patients is real risk of suffering permanent and irreversible sight loss if their treatment is delayed.

### Eye care measure data by health board – January 2025

Health Board	Total number of patient pathways assessed as being at highest risk of irreversible harm <b>waiting for an appointment</b>	Number of patient pathways assessed as being at highest risk of irreversible harm <b>waiting beyond target date</b>	Percentage of patient pathways assessed as being at highest risk of irreversible harm <b>waiting beyond target date</b>
Wales	161,902	80,826	49.9%
Betsi Cadwaladr	43,258	23,255	53.8%
Powys	2,047	611	29.8%
Hywel Dda	18,113	11,922	65.8%
Swansea Bay	21,121	5,143	24.4%
Cwm Taf Morgannwg	29,809	17,378	58.3%
Aneurin Bevan	29,463	16,094	54.6%
Cardiff and Vale	18,091	6,423	35.5%

### Additional information

- RNIB Cymru (2024), [Vision for a Fairer Future: Priorities for the new Cabinet Secretary for Health and Social Care](#)
- Senedd Research Service (2024), [“Eye Watering” – Ophthalmology Waiting Lists in Wales](#)
- Institute of Welsh Affairs (2024), [It’s time to end avoidable sight loss in Wales](#)
- National Assembly for Wales, (2019) Public Accounts Committee [Management of follow up outpatients across Wales](#)

- Wales Audit Office (2018), [Management of Follow Up Outpatients Across Wales](#)
- RNIB Cymru (2014), Real Patients Coming to Real Harm

Document ends.

# Agenda Item 7.1

Y Cynullin Senedd a  
Cofal Cymdeithasol

## Health and Social Care Committee

Sarah Murphy MS  
Minister for Mental Health and Wellbeing

27 January 2025

Dear Sarah

### Welsh Government draft budget 2025-26

I am sorry that you were unable to attend the Committee's scrutiny session on the Welsh Government's draft budget. I hope you are feeling better.

Although we were able to put a number of questions relating to your portfolio to the Cabinet Secretary, there were a few outstanding matters and I would be grateful if you could respond to them in writing:

### Mental health

1. Your evidence paper states that health boards need to make better use of existing resources rather than seeking additional funding for mental health. Can you clarify what specific measures or changes you expect health boards to implement, and how these will ensure services can meet growing demand and maintain quality of care?
2. The mental health ring-fence ensures that health boards maintain a minimum level of investment in mental health services. Can you confirm if any health boards have failed to meet this minimum investment level and, if so, what are the consequences of not meeting this requirement.
3. In the absence of a revised Mental Health Strategy, can you set out the Welsh Government's current priorities for mental health and clarify how these priorities are reflected in the draft budget, particularly in terms of the areas of service provision being prioritised and the balance between investment in preventative care and specialist support.
4. During its scrutiny of the Welsh Government's draft budget, the Children, Young People and Education Committee was told that it is not possible to determine how much health boards invest in specialist child and adolescent mental health services (CAMHS), despite long waiting times and documented challenges in achieving timely interventions. This information is essential to understanding why desired outcomes have not been achieved, so can you advise

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how you can ensure investment levels are sufficient and used effectively to improve outcomes without this data.

### **Children's health**

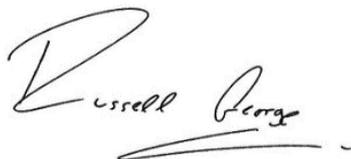
5. Can you confirm whether the Welsh Government has de-prioritised children's health in this year's NHS Planning Framework guidance/ Health Board allocations, given the absence of specific directives to health boards to safeguard children's services (which were highlighted as disproportionately impacted by pressures in last year's NHS Wales Planning Framework)? And does this reflect an assumption that issues for this group have been sufficiently addressed?
6. Can you confirm when you expect the children's health quality statement to be published. And, in the meantime, can you provide us with a detailed list of priorities and workstreams for the clinical lead on children's health within the NHS Executive, and clarify how this budget is supporting their progress.

### **Women's Health Plan**

7. Do you believe the £3 million allocated for the Women's Health Plan in 2025-26 will be sufficient to meet key actions set out in the Plan?
8. As this is a ministerial top priority, is this allocation adequate given it represents a relatively small portion of overall health spending?

It would be helpful if we could receive your response by Friday 21 February.

Yours sincerely

A handwritten signature in black ink that reads "Russell George". The signature is written in a cursive style with a long horizontal stroke underneath.

Russell George MS  
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

# Agenda Item 7.2

Y Gweinidog Iechyd Meddwl a Llesiant  
Minister for Mental Health and Wellbeing



Llywodraeth Cymru  
Welsh Government

Russell George MS  
Chair  
Health and Social Care Committee  
Senedd Cymru

6 March 2025

Dear Russell,

I apologise for not attending the Health and Social Care Committee's Draft Budget scrutiny session on 16 January. Thank you for your questions, which I have answered in the order you sent.

## Mental Health

**Q1** The new *Mental Health and Wellbeing Strategy* and the *Suicide and Self-Harm Strategy* are being developed in the current financial context and 2025-26 Budget – we do not have a budget or indicative spending plans beyond 2025-26. As such, they will provide direction to the wider health and care system, and to partners, about how resources can be targeted to support good mental health and to prevent suicide and self-harm.

Our overarching aim is to improve access to mental health services, throughout the life course and to provide services, which are person-centred, and needs-led. This will be achieved through different models of evidenced based care with a focus on earlier intervention. Further details will be included in the final strategies, which are due to be published in the spring.

We have set out clear expectations in the NHS planning guidance to develop mental health services and, as part of the work to deliver the strategies, we will be developing quality statements for mental health to drive service transformation. The NHS Executive has already developed a service specification for child and adolescent mental health services, which is designed to reduce the variation we currently see across Wales.

We invest in £2.2m annually in the NHS Executive to develop a Strategic Programme for Mental Health and a Patient Safety and Suicide and Self-harm Programme. This provides dedicated resource to NHS Wales to drive improvements in performance, quality and safety. This work will continue to support health boards to meet waiting time standards on a sustainable basis and to reduce variation.

**Q2** The ring-fence acts as a spending floor beneath which health boards should not drop. We are also clear that where efficiencies have been made, it is expected that these are reinvested in mental health services. No health board has failed to meet this minimum investment.

**Q3** The new *Mental Health and Wellbeing Strategy* is being finalised so has not been published yet. However, we have published the consultation summary report, which confirmed there has been broad support for the draft strategy. The draft strategy gives a clear view about our current priorities and the focus on prevention, earlier intervention and more joined up, seamless mental health provision. The draft strategy and consultation summary are available [here](#).

The final strategy and delivery plan will provide further details about how this will be implemented. The priorities in the strategy have already informed the Strategic Programme for Mental Health, which aims to improve the quality and access to mental health support and reduce variation between health boards. It includes a patient safety programme, which will initially focus on improving inpatient provision.

**Q4** Officials meet with health boards every month to monitor the quality and performance of services, including CAMHS. Health boards have trajectories and plans to improve mental health services. We are seeing good progress in reducing waiting times for CAMHS.

We are developing a series of service specifications – as referred to in the answer to your first question – CAMHS will be prioritised. These will set out the core service offer, principles, access requirements and response times, which will provide a template against which health boards are monitored. The CAMHS specification has been finalised, and health boards have been benchmarked against it. Health boards are now developing improvement plans to achieve the specification and the NHS Executive will monitor progress. The *Mental Health and Wellbeing Strategy* will also set out expectation for improved data across mental health services so we will have a wider set of metrics to inform future financial planning exercises.

### Children's health

**Q1** Children's health has not been de-prioritised. The strategic priorities outlined in the planning framework apply across the age-range. We continue to monitor and support children through the Healthy Child Wales programme, which provides a universal health offer for all families, and targeted support through Flying Start, which is our flagship early years programme. Both play a crucial role in improving health outcomes, promoting child health, and wellbeing for children in Wales.

We have published a new unified operating model to underpin the existing school nursing frameworks in Wales. It will extend the current Healthy Child Wales programme by extending the universal public health offer to all compulsory school-aged children, regardless of setting.

**Q2** We are working with the Children's Health Network to develop the *Quality Statement on Children's Health*, which will set out our clear expectations about the high-quality services health boards are expected to deliver. Engagement with stakeholders will take place over the summer and we expect to publish by the end of 2025.

### Women's health

**Q1** The *Women's Health Plan* has been written by National Strategic Clinical Network for Women's Health, part of the NHS Wales Executive and is a blueprint for enacting the *Quality Statement for Women and Girls Health* and the outcomes of the Discovery phase work. The new funding in the Draft Budget will help to deliver the actions in the plan, specifically the pathfinder women's health hubs by March 2026.

Additional funding has been secured to support women's health research. I am very pleased we have been able to announce a further £3m from Health and Care Research Wales to develop the Women's Health Research Wales centre for excellence.

**Q2** The *Women's Health Plan* is an ambitious 10-year plan and I am determined it will drive real improvements in women's health and outcomes; it will advocate for women and girls in the NHS and will empower women to be heard when accessing healthcare. It demonstrates how the NHS will implement the changes needed to meet the *Quality Statement for Women and Girls Health*.

Yours sincerely

A handwritten signature in black ink that reads "S. Murphy". The signature is written in a cursive, flowing style.

**Sarah Murphy AS/MS**  
Y Gweinidog Iechyd Meddwl a Llesiant  
Minister for Mental Health and Wellbeing

## Y Pwyllgor Deisebau

### Petitions Committee

Chairs of Health and Social Care Committee;  
 Economy, Trade and Rural Affairs Committee;  
 Equality and Social Justice Committee; Children,  
 Education and Young People Committee; Wales  
 Covid-19 Inquiry Special Purpose Committee

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07 March 2025

Dear Chair,

#### Petition P-06-1488 Establish a 'Care Society' to Tackle the Long COVID Crisis in Wales

The Committee considered the above petition during its meeting on 17 February, alongside correspondence from the Cabinet Secretary for Health and Social Care and the petitioner.

During the discussion, I noted key points raised in my prior meeting with the petitioners. Members acknowledged the wide scope of the issues raised, which extend beyond the remit of the Petitions Committee. It was clear that addressing these concerns would require a cross-governmental strategy from the Welsh Government.

As a result the Committee agreed to write to the First Minister, with relevant Cabinet Secretaries copied in for awareness, to inquire about the Government's cross-portfolio strategy for addressing long COVID, particularly in relation to individuals who are either unemployed or facing difficulties returning to work due to potentially undiagnosed long COVID.

Additionally, the Committee agreed to write to relevant Senedd subject committees to seek more information on your ongoing or planned inquiry work regarding the Welsh Government's strategic approach to Long COVID.

The full details of the Committee's consideration of the petition, including the correspondence and the actions agreed by the Committee can be found here: [P-06-1488 Establish a 'Care Society' to Tackle the Long COVID Crisis in Wales](#).

I would be grateful if you could send your response by e-mail to the clerking team at [petitions@senedd.wales](mailto:petitions@senedd.wales).

Yours sincerely

Carolyn

Carolyn Thomas MS

Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

