Wales Council of the Blind Roundup

No. 32

The NHS at 70

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The next edition of Roundup will look at sight loss as a complication of other conditions.

The NHS at 70

What does the NHS in Wales look like?

The National Health Service, established by Welshman Aneurin Bevan in 1948 and launched by him at the Park Hospital in Manchester, was the start of a programme of healthcare for all. The various strands of medical support would henceforth be delivered by a single organisation.

The NHS was to be funded out of general taxation and was to be based on the following principles:

- Free at the point of delivery
- Comprehensive
- Equity
- Equality

1969 saw the Secretary of State for Wales take over much of the responsibility for health services in Wales and was supported in this by the Welsh Office, which had been established in 1964.

In Wales the Welsh Office had both regional and central government departmental responsibilities under the political control of the Secretary of State for Wales.

In Wales during the 1980s particular developments in fields of public health and health promotion emerged. The Welsh Health Promotion Authority launched, in 1985, 'Heartbeat Wales' which sought to reduce the level of heart disease across the principality. In 1989 the Welsh Health Planning

Forum published the ‘Strategic Intent and Direction for the NHS in Wales’ which pioneered the concept of ‘health gain’.

In 1996 the ‘Fresh Start’ document in Wales merged the District Health Authorities and Family Health Services Authorities into 5 Health Authorities covering the whole of Wales.

In 1997 a Labour Government was elected to the UK Parliament. In January 1998 the Secretary of State for Wales published ‘Putting Patients First’. In England the Secretary of State for Health had previously published ‘The New NHS: Modern and Dependable’. Although the split between commissioners and providers of healthcare remained, GP Fundholding was abolished with the primary care focus on commissioning shifting to the newly established Local Health Groups which were part of the 5 Health Authorities.

1998 saw the publication of ‘Better Health Better Wales’ which explicitly made the link between poverty and ill health. The last year of the 1990s also saw the fruits of devolution in the establishment of the National Assembly for Wales.

“Improving Health in Wales – A Plan for the NHS with its partners” (2001) proposed new structures and organisational change for the NHS in Wales. The structure was developed to meet the following principles regarding the relationship to the service with its users and other partners:

- Simpler for patients to understand
- Accountable for the actions it takes and the service it delivers
- Stronger democratic voice in the way it is governed

NHS Wales is Wales' largest employer – some 72,000 staff - providing public healthcare through its seven regional Health Boards.

Structure

In 2009, a reorganisation of the NHS in Wales abolished the 22 Local Health Boards and 7 NHS Trusts and replaced them with a simpler system empowering seven geographically determined Health Boards to deliver all NHS services, instead of the two-tiered system of Trust and LHB that had existed since 2003.

Cardiff and Vale University Health Board houses the University Hospital of Wales in Cardiff which is the third largest hospital in the UK.

There is a number of 'all-Wales' NHS Trusts. These are currently the Welsh Ambulance Service, whose two-and-a-half thousand staff provide ambulance and related services; the Velindre NHS Trust – a specialist provider of cancer services and the Welsh Blood Service; Public Health Wales delivering a range of functions to reduce health inequalities and to improve health and wellbeing; and the brand new Health Education and & Improvement Wales, aimed at workforce development.

In addition, there is a number of other bodies that support the service – Health Commission Wales, the Shared Services Partnership, the Informatics Service, NHS Direct Wales and eight Community Health Councils. The Community Health Councils are regional interfaces to the public that monitor the quality of services and provide information about available services. NHS Direct Wales is the 24 hour health advice telephone service, which advises people on their immediate health concerns.

A brief history of Ophthalmology in the NHS.

To celebrate 70 years of the NHS, this article has been compiled from a number of pieces by Carl Pierce, who was Clinical Nurse Manager in Ophthalmology in North Wales from 1961 to 2001. He gives a fascinating insight into the changes that has witnessed in ophthalmology over the decades.

The Second World War had only recently ended and there was still austerity. When the NHS was introduced in 1948 the patients' reaction was “Gosh! Is the service free?” The public was grateful for the treatment and were willing to queue and wait. In the wards, patients brought their own eggs for breakfast and it was sister's job to boil or fry as required.

Cataract surgery was only carried out if you were nearly blind: this entailed bed fast for 10 days with both eyes covered; fed and watered; blanket bathed. Confusion was common including deep vein thrombosis and pulmonary embolism. Extracapsular surgery was carried out leaving lens matter in the eye. This caused severe inflammatory reaction and iris prolapse was common, needing more surgery and more bed rest. Patients had thick glasses that reduced their field of vision and made walking hazardous. Patients were known to fall and break their hips.

Children with squint had anaesthesia with ether, resulting in vomiting in many cases. Both eyes were padded from 5-10 days and no visiting was permitted. Inflammation of the eyelids (blepharitis) and corneal ulcers were common.

Patients with retinal detachments were often kept in bed for up to three weeks and diathermy – an electrically generated heat treatment - was the choice for surgery. Leeches were in common use and teeth were removed for iritis, an inflammation of the iris. A special dental day for tooth extraction was held at the Hospital. A big breakthrough was Diamox to help reduce intra-ocular pressure. Before this, surgery often

had to be carried out on hard, red eyes. Atropine and Hyoscine poisoning from eye drops often occurred.

In 1954 the Eye Unit in HM Stanley opened and Mr. Edward Lyons was appointed as Eye Surgeon to North Wales. However, there were no beds available and surgical cases were referred to Liverpool.

The ability to perform surgery at the Hospital did not arise until 1961 when the Eye Theatre was opened. The Eye Unit at that time consisted of 16 beds and 4 children's cots. Cataract surgery was only carried out if you were nearly blind. Initially, instruments were sterilised in disinfectant fluid until a hot-air oven was acquired.

The décor of the unit included a coal fire and dark brown tiles. Drums with dressings were packed on the ward and sterilised by the porters. No training! Eye pads were cut from gamgee tissue by the nurses, resulting in blistered fingers. Sheets were changed once a week with the top sheet put on the bottom so you only change one sheet per week. Blankets were wool and were dry-cleaned once a year, the whole ward being closed for up to a week. Between patients, beds were washed down with carbolic. Nurses washed their hands with washing soap. Only Consultants were allowed to use toilet soap. Anything white was starched, and there was only one glass thermometer per ward. If you broke a thermometer you reported to the matron. Syringes and needles were washed and used again and again. Only when needles had hooks on were they thrown away!

Waiting lists were long with operating lists held twice weekly – there was no microscope or prepared sutures (stitches). The Unit had one consultant and shared a Junior Doctor with the Ear, Nose and Throat Clinic. The one Night Nurse on duty was required to wash all patients. Only one set of drops was available to be shared for 'clean patients' and one set for 'dirty patients'.

The 1960s saw major changes in Cataract surgery: the whole lens could now be removed with a special ice probe and silk sutures were introduced. Surgery was safer and eyes healed with fewer complications. Artificial lenses were beginning to be inserted into the eye to replace the lens that had been removed, resulting in dramatic improvements in vision and removing the need for thick glasses. The Eye Unit had the first Operating Microscope in Wales, improving

surgery considerably. A hand-held Fundus camera was purchased – another first – producing excellent photographs of the inside of the eye. Also, disposable syringes and needles were introduced. An Orthoptic Department was also started with a single-handed orthoptist in a clinical room in the Eye Outpatients Department.

By the 1970s a much-improved Fundus camera allowed introduction of flourescence angiopathy. Treatment of diabetic eye changes could now be carried out using a Xenon arc laser – before this you simply became blind. Cataract surgery now had the advantage of finer sutures produced commercially that were no longer threaded by hand. The department appointed a second Consultant in 1974.

In the 1980s there was a major upgrade of the Unit following a move of the Ear, Nose and Throat (ENT) Department to Ysbyty Glan Clwyd. A new clinic area was created and the ward and theatre upgraded. The purchase of additional Argon & Krypton lasers widened treatment options for some patients. A development in surgical technique in cataract surgery resulted in safer operations and improved outcome where the back membrane could be preserved where a new lens could be fitted. The first Ophthalmic course commenced in Wales, and has remained the only post-graduate study course for nurses in the Principality, and the Bristol Eye Bank was established.

Further dramatic changes were seen in the 1990s, brought about by the Hospital gaining Trust status. The Ophthalmic Directorate was set up, and became fully responsible for quality assurance, meeting contracts and finance targets. Computers were introduced into the Directorate and a third Consultant employed. Cataract surgery employs the phacoemulsification technique with the use of improved lens implants. By now Day Surgery was the order of the day with over 80% of surgery carried out as day care. Beds were reduced from 24 to 8 as the Day Care unit adopted preferred reclining chairs. The Nurse Practitioner role developed formally to provide a casualty service and shared care in glaucoma clinics.

The Directorate moved from strength to strength because of staff who have a 'can do' culture and a 'win-win' outlook.

The new millennium saw further expansion of digital services enabling new treatment options for a variety of patients including those with

macular degeneration. This service expanded both locally and nationally with the advent of NICE (National Institute of Clinical Excellence) guidance and available pharmaceutical products producing a significant increase in the volume of patients able to access treatment for their condition. The Eye Clinic Liaison Officer (ECLO) role was also introduced to the Unit in conjunction with Macular services to provide a supporting role for those with low vision needs. In addition this was the decade that patient support groups were developed within Ophthalmology, with monthly meetings scheduled for those affected by Glaucoma and a Low Vision support group.

In 2011 the Eye Unit comprised a Day Care Unit, two operating theatres, out-patient department, casualty triage unit, an Orthoptic Department, and peripheral clinics on five sites. Approximately 5,000 surgical cases were performed annually. The Ophthalmic Outpatient Department saw over 40,000 patients annually in addition to casualty attendees, and provided formal ophthalmic nurse training at post-graduate degree level and advanced skills utilisation for ophthalmic nurse practitioners. The Unit strived continuously to develop and provide quality patient care, and continued to do so following the relocation of the service from HM Stanley to Abergele Hospital in 2012.

A patient’s experience…

“I’ve had a number of admissions for day treatments and one overnight stay. The outpatient and inpatient support I got at Morriston Hospital was excellent! For my overnight stay, everyone from nurses to catering staff was aware of my needs as a person with no sight. An example is when tea was brought to me, the handle was turned towards me and I was told where the cup was. This, I have to say, was in complete contrast to an experience at Singleton Hospital where the food tray was brought to me without me knowing and subsequently taken away untouched! I asked when I was going to have a meal, since everyone else seemed to have had theirs, and I was told that it had come and been cleared away.

“Also, I had problems at Glangwili Hospital as an outpatient. I asked to be shown to a quiet area so that my guide dog wouldn’t be disturbed

by the other patients trying to move around. They showed me to a seat, but I didn’t know that it was in a corridor. A patient’s wheelchair, which was being pulled backwards by a relative, went over my dog’s paw. I was then moved me to a narrower corridor where people had to step over the dog to get past. I found it so stressful that I began to leave the department, and explained to a nurse why I was leaving. So, they found me a quiet room, I wished they’d given me that room in the first place!

“At Glangwilli Hospital A & E department the nurse was paying more attention to my guide dog, which resulted in me walking into a chair. To add injury to insult, the nurse used the wrong cuff for my blood pressure test resulting in bruising to my upper arm. Following that, I was asked into a room by a doctor, who didn’t explain what room I was being taken into. It was a visitor’s waiting room and the doctor wanted to examine me in there. There was no privacy and the doctor took my blood in there. I’ve complained to Hywel Dda Health Board and it was suggested that I go in to talk to staff about these issues and how to avoid them, but I’ve not been invited yet.

“On a positive note, at a follow-up appointment in Llanelli hospital it felt like a five-star clinic. I was helped by a nurse who gave me clear directions to everywhere I needed to go. The doctor also explained everything to me. I was so impressed I had to compliment them on the treatment I got there, because it really took me by surprise, after everything I had experienced in other hospitals.”

Annual Wales Eye Care Conference 2018: Celebrating 70 Years of the NHS

Vaughan Gething AM, Cabinet Secretary for Health and Social Services in Wales, delivered his keynote speech to the conference.

The NHS turned 70 years old in July. This conference provides the perfect opportunity to celebrate the achievements of one of the nation's most loved institutions and one of the worlds most respected.

The world has changed significantly; people are living longer and have very different lifestyles, placing greater demands on our services.

Launched in 1948, the NHS was based on the three core principles of providing care that meets the needs of everyone, is free at the point of delivery and is based on clinical need, not the ability to pay. Those principles are as much a core of today's NHS as they were in 1948 - we still hold the same principles and see it as our duty not only to protect them, but also to celebrate the proud history of healthcare they have inspired.

Wales was not just the birthplace of the NHS but through the seven decades of its life, Wales has led developments that determined the quality of life of generations of people.

Even before the advent of devolution Wales was leading the way on developing and improving health services. In 1971 the GP Julian Tudor Hart described the Inverse Care Law and the challenges of accessing health care by those in greatest need.

40 years later Julian’s work is still being used to shine the light on inequalities in health and points the way to target areas of high inequality and to improve access for all.

Since devolution in 1999 Wales has led the UK on many developments:

- The ban on smoking in enclosed public spaces in 2007;
- Free prescriptions in 2007;
- The opt-out organ donation system in the Human Transplantation (Wales) Act 2013.

A number of specific eye care developments have also been introduced.

The NHS Wales Eye Care Service in 2001 - enabling optometrists and ophthalmologists to work at the top of their licence and to reduce the number of patients being referred into hospitals.

Eye health care has developed differently in Wales to the rest of the UK; the main difference is the Wales Eye Care Service. There are two aims - to preserve sight through the early detection of eye disease and to provide help to those who have visual impairment for which further treatment is not appropriate. The first aim is served through the Eye Health Examination Service and Diabetic Eye Screening Service, the second is through the Low Vision Service.

The Wales Eye Healthcare Delivery Plan was launched in 2013 - further improving eye health and support for those living with sight loss. The Plan set out a range of key actions to improve the eye health of our citizens, specifically those most vulnerable to eye health problems and sight loss.

The All Wales Standards for Accessible Information for People with Sensory Loss, also launched in 2013, setting out the standards of service delivery people with sensory loss should expect to be met when they access healthcare. A requirement is for people who need communication support, to have this need met. As a result of the requirement a national project is underway to record and flag the communication needs of service users.

In this conference Heather Payne and Rebecca Bartlett presented the Children's Vision Pathway for 4 -5 year olds, launched in 2015. The Pathway reflects the vision for prudent health in working towards achieving health and wellbeing with the public, patients and professionals as equal partners.

I am proud of these examples and how we have delivered against 1948 funding principles.

The recent Parliamentary Review described the increasing demands and new challenges we face – an ageing population, lifestyle changes, public expectations and new and emerging medical technologies. The Review made a strong case that a service based mainly on a medical model of health and a separate system of social care, is not fit for the future. Our focus has to be on transformation, innovation and delivery knowing we have foundations to build on in our current system. Without response and change we will fall short of meeting the needs of the Welsh population. The launch of 'A Healthier Wales' is our Plan for health and social care;

I am pleased to announce the Welsh Government recently agreed the introduction of outcome focused measures for eye care.

Formal reporting will commence in April. There is a requirement to achieve current Referral to Treatment Targets - supported by some investment and based on health board's achieving sustainability.

There will be a drive for health boards to implement these changes at pace. £4m non-recurrent funding will be available over the current and next financial year for primary care services to develop and the necessary eye care pathway changes implemented. The £4m investment will enable expansion of Ophthalmic Diagnostic Treatment Centres and staff up-skilling to see patients in the correct setting. These will be sustainable changes, supported by implementation of the lean cataract pathway that will result in efficiency savings in future years.

You will all agree, this work is a welcome step forward.

We are all proud of the way the NHS has delivered huge advances in health care and improvements in public health which means we can expect to live longer lives.

Looking to the future, the NHS is changing, becoming more integrated and investing in new treatments, genetic research, and digital technologies. Change will continue as we work to identify how we respond to the recently published Parliamentary Review into health and social care.

'A Healthier Wales' is the Welsh Government's plan to deliver the changes needed to meet the increasing demands on our health and social services. It sets out how we will develop new models of seamless local health and social care, scaling the

best local innovations, initially at the regional and then national level.

Our vision is that everyone in Wales has longer healthier and happier lives; able to remain active and independent in their own homes, for as long as possible; everyone's physical and mental well-being maximised from birth through all life stages, with a dignified experience at the end of life.

None of this would be possible without the skill, dedication and compassion of you – NHS, social care and the volunteers, charities and communities supporting services.

I mentioned earlier the growth in life expectancy in Wales. We've succeeded in adding years to life and we must also pay attention to adding quality of life to those additional years. Many older people enjoy very long years of activity and happiness in their advancing years. We now strive to ensure older people enjoy that quality of life while at the same time ensuring those in need of care receive the support they need. As the NHS reaches its 70th birthday, we continue to plan how best to respond to these pressures and to ensure NHS Wales is fit for the future.

I am pleased to be here to take part in the eye care celebrations and to support the NHS in this special birthday year. I would like to thank you all for the contribution you make to delivering eye care to the people of Wales, across health and social care and I hope you enjoy the rest of this year's National Eye Care Conference.

Frank Atherton, Chief Medical Officer for Wales, gave the conference an overview of ophthalmic and optometric services today.

Who is the Chief Medical Officer?
I lead public health policy and programmes, working across all Welsh Government policy departments and with a wide range of external partners. A key aim is to improve health and to reduce health inequalities across Wales.

I lead the medical profession and have an important role in medical regulation; education and training, standards and performance, improving the quality of healthcare and patient outcomes.

I also maintain links with other UK Chief Medical Officers, government departments and organisations in Britain and internationally.

Eye care in Wales
In this conference we will be looking back at our history, looking around us at today's picture of eye care, and looking to the future. There are exciting developments coming into view from advances in medical science, digital technology and new ways of delivering care.

I would like to thank everyone involved in the delivery of eye care. You all make a difference to people's lives. Co-production, a key tenet of our Prudent Healthcare strategy, means everyone plays a part in delivering services. Everyone should share in the congratulations and sense of pride we feel today as we celebrate 70 years of the NHS.

We have much to celebrate in Wales. Wales Eye Care Service (WECS) aims to preserve sight through the early detection of

eye disease and to provide support to those who have low vision and whose sight is unlikely to improve.

The Together for Health - Eye Health Care Delivery Plan for Wales 2013-2020 has been a key for the development and implementation of integrated services. Moving forward to 2020, the challenges for eye care services will be to build on and replicate the good practice to date; embedding them into our teams to ensure that people receive the best possible care and support in the right place at the right time.

The Children's Vision Wales Pathway (4-5 year olds) is also unique to Wales and we will hear more on this later today. The pathway was launched in 2015 and was developed by the Children’s Vision Wales Advisory Group; formed from orthoptists and optometrists from each health board in Wales. It is co-production in action. The aim is to provide a flexible auditable pathway for school screening with onward referral to primary or secondary care to allow for the continuation of existing systems that were already working effectively.

The state of the nation – What pressure is eye care under and why? And how do we tackle those challenges?

The number of people with eye conditions is increasing and will continue to do so in the coming decades, driven in part by an ageing population. Ophthalmology continues to be one of the most in demand specialisms in the NHS, comprising 10% of all hospital appointments.

Some figures from recent years:

- During 2016-17, 776,827 General Ophthalmic Service sight tests were paid for by the NHS, a 1% per cent increase on the previous year and an increase of 15% since 2006-2007;
- 150,324 examinations were carried out by EHEW;

- The NHS in Wales performs 776, 825 eye tests a year and provides 289,515 GOS vouchers helping people with the cost of eye care;
- A total of 20,718 cataract treatments were performed in NHS Wales between April 2017 – March 2018.

Ophthalmology services are working to full capacity, providing 327,921 appointments in 2016-17. 77,555 of these were new appointments and 250,366 were follow-up appointments.

The Welsh Ophthalmic Planned Care Board has been running for several years. This was set up to work at a national level. It looks at issues of capacity and demand and the activities taking place in secondary care; the redesign of new pathways and the implementation of existing pathways.

Eye Care Collaborative Groups provide this service at a local level. Ophthalmologists have a standing invitation to attend these meetings, and I strongly encourage the ophthalmologists present today to do so. The collaborative groups that are already meeting some of their objectives have been successful by using every avenue to network across primary and secondary care, social care and third sector-building relationships to ensure that services meet the needs of our citizens and listening to the patient voice.

Prudent Healthcare is a key principle of NHS Wales, not for eye care alone but for the whole health service. Prudent Healthcare ultimately means a service that is sustainable in the long term and which focuses on delivering high quality care. It emphasises patient outcomes and aims to achieve continuous quality improvement while making best use of resources.

Successes in eye care and the new model of healthcare.
We are at time of transformation. The Welsh Government's long term plan for health and social care, *A Healthier Wales*, will rebalance care and move it from hospitals to the primary and social care settings. Services will shift from general hospitals to regional and local centres. Services will be modernised, using new technologies and sharing best practice nationally to ensure that healthcare is of an equally high quality across Wales.

Prudent Healthcare means focusing on better systems management, so that every part of the care pathway is making the maximum contribution and each person operating at the top of their clinical licence. More patients are being managed by optometrists in primary care using the Eye Health Examination Wales Service and the Low Vision Service Wales. These services are clear examples of how moving services out of the hospital and into primary care can improve the quality of care provided as per the theme of last year's conference; improved outcomes and accessibility.

Optometrists are undertaking further higher education qualifications in medical retina, glaucoma and independent prescribing across all health board areas. Optometrists currently undertaking the independent prescribing course over the next 2 years will bring about even more opportunities to improve access, service delivery and better outcome for patients. Independent prescribing in optometry will reduce the burden on GPs and ophthalmologists further and enable patients to access services and medication quickly.

Optometrists are managing eye problems safely and effectively in the community, when previously they would have been required to refer them to hospital services.

Health boards need to implement agreed programmes of work designed to reduce demand and improve efficiencies as well

as reduce their backlog of patients. If this is integrated into Integrated Medium Term Plans, implemented early in the year and the health board held to account for both aspects of this activity then it is felt that a more strategic approach to managing ophthalmology could be achieved.

I am confident that Wales will continue to develop and grow in terms of its eye care provision, bringing the citizens of Wales the right care, delivered in the right way, at the right time. Together we can transform eye care services and make a real difference to the lives of people in Wales – treating, protecting and preserving sight for as long and as well as possible.

These talks, and other talks and presentations from the conference, are available at http://www.wcb-ccd.org.uk/conference/conference_files.php

A patient's experience…

"When using my local doctors in the main there is no problem other than the literature provided for information is in small print and that you are expected to tap in your details on a computer fixed to the wall which I find impossible. I end up having to deal with the reception which can be uncomfortable at times.

"Most of the community hospitals I have used have similar problems but with the added problem of signage. Some of the signs are above doors and are difficult to see.

"The main large hospitals have all the above and looking for various departments can be a day out. Whilst looking for department E in Glan Clwyd I found ABCD and FG but no E only to be told at reception that E was by the main entrance before A confusing. Also each department has its own reception half the time not manned and poor signage so you don't know where you are, even with someone helping you it can be difficult. Then of course there is trying to find your way out. There are signs saying way out but there are so many different ways out you don't always end up going out through the door you came in."

Our Big NHS Change: Hywel Dda Health Board Consultation

As reported in the News Section, the Your Voice: a Shared Vision West Wales Group met with representatives from Hywel Dda to discuss the consultation. We requested an update from Anna Bird at Hywel Dda on the state of the consultation.

This consultation closed on the 12th July and a public extraordinary meeting was held on 26th September. The Health Board considered the feedback from the consultation and engagement, which had been analysed by a team of independent experts. Eleven recommendations from clinicians (doctors, nurses and a range of healthcare professionals such as health scientists and therapists) were approved and can be read in full here: https://bit.ly/2NJxft5

In summary, the decisions include:

- more investment will be made in the integration of social care with health and well-being across the seven localities (north and south Ceredigion, north and south Pembrokeshire, Taf/Tywi, Amman/Gwendraeth and Llanelli);

- a hospital model, which includes:
  - a business case to be made to Welsh Government for a new hospital in the south of Hywel Dda (somewhere between Narberth and St Clears) to provide specialist urgent and emergency care services and planned care;
  - hospital services to be retained and developed at Bronglais Hospital, Aberystwyth, in line with the Mid Wales

Joint Health & Social Care Committee recognising the importance of hospital in delivery of services to populations of Ceredigion, Powys and south Gwynedd;

- acute medicine to be retained at Prince Philip Hospital, Llanelli, following recent modernisation of services developed with the local community and serving a densely populated area;
- re-purposing Glangwili (Carmarthen) and Withybush (Haverfordwest) hospitals to support community health needs including overnight beds, day case procedures, out-patient and walk-in services such as minor injuries and much more.

Our Big NHS Change consultation, between April and July this year, was one of the largest local NHS consultations in the UK and saw a huge and passionate response from our local population. Responses included more than 5,400 questionnaires, 4,000 attendees at events and workshops, hundreds of written submissions, five petitions and extensive social media debate.

Whilst some key decisions were made, the Health Board received really insightful feedback from people during the consultation and wants to investigate further, and demonstrate, some developments, including:

- put in place a staff plan to deliver future models and provide opportunities for staff;
- a commitment to work with people and organisations to develop integrated networks (as opposed to hubs) which are unique to the needs of their community and to consider the geographical areas highlighted in the consultation as gaps in current provision;
- work with the community on an early model of the above in Pembrokeshire, focusing on the ability to provide more

community based care 24/7 and to demonstrate how it could work and the impact it could have;

- work with local people to explore potential for a range of different types of beds within the local community – whether in existing community hospitals, at home or another setting, with a particular focus on Amman Valley Hospital;
- review, test and challenge the model for acute medicine to be responsive to demand and changes in patient flows associated with the whole system change;
- work closely with Abertawe Bro Morgannwg University Health Board (ABMU) on services where patients could benefit from a regional approach;
- examine the opportunities a new hospital and community model could offer maternity and child health services to ensure doctor and midwifery led care, and care for children (paediatrics) and sick babies (neonatal) are maintained within the boundaries of the Hywel Dda area;
- align with the transformation work in mental health services to ensure mental health and learning disability assessment and treatment units are provided at the new urgent and planned care hospital;
- investigate the practicalities and impacts (through a feasibility study and options appraisal) of locations between Narberth and St Clears for the new hospital;
- work with people living and working in the areas furthest from a new hospital to provide additional support for emergency and urgent care (potential to look at things like placing paramedics within in a community as opposed to within a vehicle);
- respond to public anxiety over the ability to manage emergency conditions that are time sensitive (e.g. ST Elevation Myocardial Infarction STEMI, stroke and sepsis);
- consider the opportunities a new hospital in the south would provide Bronglais Hospital;

- work closely with other organisations, including county councils and the third sector, to develop Glangwili and Withybush hospitals;
- develop a detailed plan to address concern heard in consultation regarding access, travel, transport and infrastructure, working with the Regional Transport Group, communities (including those with protected characteristics in response to the difficulties we heard about from people and the equality impact assessment) and Welsh Ambulance Services NHS Trust;
- formally state the Health Board's support for provision of a 24/7 service to bring medics to the scene of an accident (e.g. the Emergency Medical Retrieval Transport Service, which currently operates 12 hours a day and CHANTS (Neonatal Retrieval Service));
- develop a plan to maximise use of technology in health and care, backed up by secure IT so patient data is safe and joined up between services in the hospital and community;
- work with education and university partners to train a workforce with the skills and expertise to work in the new service model, and drive research, innovation and evaluation into our service development;
- continue to talk the public, staff and interested organisation about all that we do, especially focusing on people with protected characteristics.

The Health Board is committed to continuing to engage with patients, carers and stakeholders. If anyone is interested in finding out more information about becoming a member of Siarid Iechyd/Talking Health member which is our involvement and engagement scheme that allows people to get involved in designing services please telephone or email the Engagement Team on 01554 899056 or email talking.health@wales.nhs.uk.

Glaucoma and the NHS

The IGA is *the* charity for people with glaucoma – an eye condition that can lead to loss of sight. Our mission is to raise awareness of glaucoma, fund research into early diagnosis and treatment, and provide support to people living with the condition.

About Glaucoma
Glaucoma is the name given to a group of eye conditions in which the main nerve in the eye (known as the optic nerve) becomes damaged, usually as a result of increased pressure in the eye. The most common type of glaucoma is Primary Open Angle Glaucoma which starts slowly, and initially there are no symptoms so people often don't realise they have the condition until it's fairly advanced. Typically peripheral vision is lost first, but this often goes unnoticed because the central vision that we use for reading and recognising faces remains good. Eventually vision may become misty and patchy, and this worsens if left untreated. The loss of peripheral vision can make people with glaucoma prone to falls, and glaucoma can eventually lead to blindness although this is rare, especially with early detection and adherence to treatment.

We estimate that there are over 600,000 people living with glaucoma in the UK today, but crucially, half of them don't know they have the condition. Glaucoma affects about 2 in every 100 people over the age of 40, but gets much more common as we get older.

Early recognition of glaucoma dates back to the 17th Century but it wasn't until the 19th century that we learned that left untreated, glaucoma can lead to blindness. Since the launch of the NHS back in 1948, diagnosis, treatment and management of glaucoma has improved hugely. Today, most cases of glaucoma are picked up during routine eye health checks with an optometrist or opticians.

The aim of most glaucoma treatment is to reduce the pressure in the eye to a level at which no further damage occurs to the optic nerve. First line treatment is usually with eye drops that help to reduce the amount of fluid being produced by the eye, increase the rate of drainage of fluid from the eye, or both. There have been major advances in medical eye drop treatment in recent years, and the

newer drops are far more effective and have fewer side effects than those previously available.

Each Health Board in Wales now has an eye care group, formed in response to the Welsh Eye Care Delivery plan. Back in 1948 the average life expectancy for men was 66. With today's ageing population now living on average more than ten years longer, eye health demands will increase, and this sector is receiving more attention than ever before.

Wales NHS has set up Ophthalmic, Diagnostic, Treatment Centres (ODTCs) where people diagnosed with glaucoma are be regularly monitored to ensure that the condition remains stable. They are manned by staff such as orthoptists and technicians. If their condition is deteriorating, they can be fast tracked back to the main eye clinic for further investigation. These centres are either in district hospitals or in contracted private optometric practices where skills and equipment have been upgraded. The advantage to the patient is that the centres are closer to home which makes the journey more convenient and hopefully less stressful. It also relieves pressure on the main hospital clinics.

Today medicines management has a big role to play in helping people with their medication. It's vital in glaucoma treatment that eye drops are used properly and consistently, and some people will need help in the form of eye drop aids, or help to learn a technique to put them in. Pharmacy technicians from Cwm Taf Health Board, visit patients at home to help them use their drops, and they also train domiciliary care workers to help their clients if needed.

If eye drops can't stabilise a person's glaucoma, there are other types of treatment available such as laser therapy and surgery, in place of or in addition to using eye drops.

Trabeculectomy is the most common type of surgery and reduces the eye pressure by increasing the outflow of fluid from the eye. Glaucoma surgery is usually carried out under local anaesthetic, but on occasion can be performed under general anaesthetic.

Laster treatment is increasingly common and involves a high-energy beam of light aimed at part of the eye to stop fluid building up inside it.

In the last 10 years we have seen the development of MIGS – or Minimally Invasive Glaucoma Surgery. These procedures use small stents or implants to lower intraocular pressure, and some claim their lower side-effect profile is transforming the face of glaucoma surgery.

Artificial Intelligence - AI
Working with consultants at Moorfields, Google's DeepMind has developed an AI programme that has the potential to prevent irreversible sight loss by spotting the key signs of eye disease from OCT scans as accurately as world-leading experts can.
An OCT scan uses light rather than X-rays or ultrasound to generate 3D images of the back of the eye, revealing any abnormalities that may be signs of disease. Deep Mind has taught itself to recognise the clinical signs that mean a patient needs further attention, and scientists now plan to push forward with clinical trials under a five-year development programme.

International Glaucoma Association (IGA)
Office 01233 64 81 64
Sightline 01233 64 81 70
Website www.glaucoma-association.com

A patient's experience…

"I had received an excellent service during my visit to Prince Philip Hospital for an operation. I was offered an opportunity to come into the hospital the day before my operation so that I could get to know the environment. This enabled me to feel less anxious and helped me focus on the operation. I was able to find my locker, my bed and to know where the shower is. I could pace out the ward so that I became familiar with the layout. All this gave me extra confidence to face the operation itself."

Nystagmus progress

Nystagmus used to be dismissed as a condition you couldn't do anything about. In recent years, though, attitudes have changed, thanks largely to research in the UK, where the NHS makes co-operation easier than in some other countries. The progress here is setting the pace internationally, with researchers in the rest of Europe, America, Australia and India all keen to learn from the UK.

Researchers in Leicester and Southampton have made big breakthroughs in the past decade in diagnosing nystagmus in children. OCT (Optical Coherence Tomography) scans and genetic testing mean more patients are now getting a more accurate and faster diagnosis. This reduces anxiety – especially among parents of newborns – allows treatment of associated conditions and better management of the nystagmus.

There's a way to go yet in ensuring that all patients benefit from these advances in diagnosis and information. But the publication in 2017 of a nystagmus information pack[1] for orthoptists by Sheffield University is a step in the right direction. We're at the early stages of understanding the genetics of nystagmus too. But genetics holds out the long term prospect of treatments using gene therapy.

Adults who develop nystagmus (acquired nystagmus) due for instance to a stroke or Multiple Sclerosis have reason to hope too. Virtual reality goggles may soon give them a stable image and remove the terrifying sensation that the world is moving continuously. A small number of people with acquired nystagmus may also benefit from an innovative approach being trialled in London using tiny magnets.

Treating, preventing and possibly even curing nystagmus will vary depending on factors such as your age and associated conditions. It's clear that there will be no single magic cure for everyone. And that's why work at Cardiff University is so important too.

The Cardiff team is investigating some of the basic mysteries surrounding nystagmus. Why, for instance, do so many people with

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1 www.sheffield.ac.uk/polopoly_fs/1.741447!/file/Nystagmus_Information_Pack_part_1.pdf

nystagmus have a null zone where their eyes move less? Are eye movement systems in the brain affected? And, perhaps most intriguingly of all, why do people who have nystagmus since infancy actually see a stable world?

John Sanders, October 2018

Did you know …

- When the NHS started, one of the major things requiring treatment was foreign bodies in the eye, as there wasn't much 'health and safety'. Factory workers often got metal in their eyes.

- Most procedures used in 1948 hadn't changed since the 1930s.

- Cataract removal was the most common procedure, but it was quite risky and the patient had to wear thick glasses afterwards. The patient was in hospital for at least one night.

- In the 1950s, the Ridley lens was developed, transforming treatment, although there were some complications. However, cataract surgery now takes only 10 to 12 minutes, and is very safe.

- In the 1960s angiogram imaging started to be used to photograph the eye. This transformed the diagnosis of retinal disease and is still used for diagnosis and to help in deciding treatment. 70 years ago, capturing images had been very difficult – artists used to examine the eyes (for around 30 minutes) and then produce detailed watercolour paintings! These were used for teaching.

- In 1967 an eye bank was established at Moorfields. Previously patients had to wait in hospital for a donor eye to become available, and could be there for weeks!

- Nowadays the most common procedure is injecting to treat AMD.

Diabetic Retinopathy Screening

Diabetic retinopathy is a complication of diabetes which can damage your sight and even cause blindness. It is one of the leading causes of visual impairment and blindness in the UK, particularly among working age people.

High blood sugar levels over a prolonged period can cause damage to the tiny blood vessels in the retina, which is the seeing part of the eye. The damaged blood vessels can bleed, or leak fluid, which can distort vision.

In the most advanced stages of diabetic retinopathy, new blood vessels grow on the surface of the retina. These are fragile and can bleed easily; they can also lead to scarring and cell loss in the retina. If left untreated, diabetic retinopathy can cause irreversible sight loss. Treatments include laser treatment, eye injections and eye surgery in very severe cases. Laser treatment was the first line treatment from the 1980s onwards, but since the early 2000's, treatment options have significantly expanded through both the development of laser treatment and introduction of Anti-VEGF therapy (injections).

Alongside the developments in effective early treatment for retinopathy, the four UK nations were the first in the world to introduce systematic screening for the diabetic eye disease. Screening looks for early signs of disease or condition in people who do not have symptoms. Finding a condition early gives patients the best chance of early treatment and survival.

Diabetic Eye Screening Wales (DESW) was first established in 2003 and has covered the whole of Wales since 2006. Everyone with diabetes over the age of 12 is offered an examination, if they are registered with a GP in Wales.

The test is a very simple, short examination. Eye drops are instilled to make the patient's pupils larger and photographs taken of the back of the eye to detect any changes due to diabetes. The images are reviewed and patients are either recalled during the following year,

seen earlier if there are changes that need to be monitored, or referred to hospital for further assessment or treatment.

Research published in 2017 showed that, between 2007/08 and 2014/15, there was a 49% fall in new certifications for severe sight impairment in Wales. Over the same time, the number of people diagnosed with diabetes grew by over 50,000, which was a 40% increase.

The combination of early identification and advances in treatment has made a real difference to the Welsh diabetic population over the last 10 years. You can't see in the back of your own eyes, so attending regular screening is really important to help identify any issues as early as possible.

Hospital radio

Mike Rose and Paul Johnson reflect on their work in hospital and community radio.

I began broadcasting at what was at the time BRfm in 2009 - now BGfm. I used to do two shows a week until 2014 when my wife Ginny passed away, but in 2016 I was approached by John Price station manager at NHSound, Abergavenny. I did two shows a week but because of my vision impairment they helped by making the screen words larger for me so that I could see what music was available for me to play, which made it easier to do my shows. The station manager was always happy - and still is - to help vision impaired people or other disabled people, such as wheelchair users, to do the best they can and gives encouragement to them. Earlier this year I had to give it up to stand for board of Tai Calon Housing Association here in Blaenau Gwent. Here again the organization helps with large print, but now for meetings it provides IPads, which is even better for someone like myself with visual impairment because I can adjust it to suit my needs.

I can honestly say that wherever I've gone organisations have been accommodating in that respect. The people I should thank are John Price, station manager at NHSound, Jayne Lewis, Assistant company secretary, and Marcia Sinfield, Deputy Chief Executive, and HR. These two ladies are absolutely brilliant at helping people with disabilities and visual impairment.

- Mike Rose.

I have always had a keen interest in radio and had my first taste of radio presenting at the age of 7, when I helped to present the Saturday morning children's program on Swansea Sound.

After that my interest in radio grew and grew, and would do pretend radio shows at the blind school in Bridgend with a former friend of mine. When I used to tell some of the teachers that I wanted to do radio presenting they would say it's not possible, it's not the thing blind people do.

Over the years I've put a few tapes in to hospital radios, but after leaving college I knew someone that was also involved in the local hospital radio, so she took me down on a Thursday night once a month initially. I couldn't go on air for the first few months, but then started off by doing one request, then as the weeks went on I would do more and more, they would go through the requests with me before it went to air, and do the same as the program went on. Also they taught me how to speak correctly. In the June of that year one of the presenters was off for a week, so I was asked to cover it, with help from someone operating the buttons for me.

I enjoyed it. After that I was given my own Tuesday night radio show between 8 and 10, and again had someone helping me with the buttons. After that I presented lots of other shows on

the station, until I left in 2009.

I joined Radio Tircoed when they started doing a month-at-a-time trial in 2005. It was a lot different to hospital radio, as it had people listening in the village and online. I started off by presenting the lunchtime show between 12 and 2, but now present mid-mornings on Mondays and Wednesdays between 10 am and 1 pm. As it goes out on line I get lots of listeners tuning in from as far away as Australia, and get good feedback from the listeners, who always contact me for requests and to guess my quiz.

I’ve got a special pen friend that I use to mark what songs I want to play on the CDs. I also get different singers to come in and chat and play their CDs as most of them wouldn’t get a chance on any other radio station in this part.

I get a team of other presenters who come in and help me do my programs, as we are all volunteers.

A few years ago I interviewed a gentleman who was organising a charity show, and he asked me to be in it. The night after the show I received a surprise phone call from Cliff Richard, thanking me for all the charity work I had done over the years.

That led to ITV cameras coming to the studio to film me and others, and I appeared on the Paul O'Grady show a few weeks later and met Cliff Richard, where he presented me with a basket full of stuff.

The radio station website is www.radiotircoed.com

- Paul Johnson

Letters

Eye Clinic North Road Aberystwyth

Dating back several years both the officers and members of the Aberystwyth & District Visually Impaired Club have been very concerned about the state of the Eye Clinic North Road Aberystwyth. Hywel Dda University Health Board who are responsible have stated the building is "not fit for purpose" Other comments include "it is like working in a garden shed" & "the conditions are like a third world country"

This matter was highlighted three years ago and nothing substantial has been done. In fact the situation is a lot worse. Eye Consultants have come and gone making waiting times longer.

As far as the building is concerned promises have been made and promises have been broken. Mr Peter Skitt (Hywel Dda Health Board - Clinical Director) promised approx £100,000 would be spent on re-vamping the eye clinic. It was stated that these improvements were likely to be achieved by the end of 2017. Apart from putting some bright yellow paint around some concrete bollards and moving some dental equipment hardly anything appears to have been done. On 5th Nov 2017 an e mail was sent by me to Peter Llewellyn (Hywel Dda Health Board - Operational Improvement Lead) asking for an update. Mr Llewellyn is no longer involved. I have written to Mr Skitt on numerous occasions, all my correspondence has been ignored.

The eye clinic was also shared not only with dentistry but with family planning & sexual health ie. everyone was squashed in together & it's not a very big building! Earlier this year family planning & sexual health were relocated opposite the university, half way up Penglais Road near to Lloyds

Pharmacy & Padarn Doctors' surgery. Hywel Dda University Health Board did not see fit to inform interested parties that this relocation had taken place - we learnt this from our local newspaper. Also, medical records go up and down between the eye clinic & Bronglais Hospital on a daily basis.

In our local paper (Cambrian News) there have been many 'letters to the editor' about the outrageous length of time patients have to wait for an appointment at the eye clinic. The new high tech eye scanner was put in Bronglais Hospital presumably because it wouldn't have been appropriate for it to be located in that cramped and decrepit building which is the eye clinic.

We got in touch with Mark Williams previous Westminster MP for this area and Elin Jones AM but to no avail, except for the clinic opening on a Saturday about a year ago, to clear the backlog of patients on the waiting list. Unfortunately I don't think there has been any improvement for existing eye patients they are still waiting a long time ie. a 3 month appointment may have a 6 month wait or even longer.

- Gillian Hopkins, Aberystwyth and District VI Group