NATIONAL CLINICAL STRATEGY FOR OPHTHALMOLOGY

DELIVERING THE FUTURE OF OPHTHALMOLOGY IN WALES

Executive Summary Report

September 2024

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Foreword

The diagnosis for Welsh ophthalmology services has never been clearer. More than one in 20 people across the country are waiting for an appointment, departments are struggling to fill consultant roles, and archaic digital and physical infrastructure are creaking at the seams.

Ophthalmology services are under pressure across the whole of the UK, but the situation in Wales is particularly alarming. Over the last decade, the number of people waiting for an ophthalmology appointment increased by 169% in Wales and – unlike in England or Scotland – there is no sign that waiting lists are starting to come down.

If this were a patient in our clinics, we would urgently be planning a course of treatment to prevent their condition worsening and ultimately return them to full health. The same clear-sighted evidence-led approach must now drive us towards the major reform we know is needed to improve eye care services in Wales for the long term.

This National Clinical Strategy for Ophthalmology offers a compelling, clinically-led case for a new model of eye care. By organising NHS ophthalmology services around local patient need rather than administrative boundaries, we can better target investment and prioritise integration and efficiency to deliver more high-quality care.

Alongside reform must come investment. Nowhere is this more urgently needed than for our outdated physical and digital infrastructure. A recent Royal College of Ophthalmologists survey of clinical leads found that no ophthalmology department in Wales has a well-functioning electronic patient record (EPR) system, interoperable patient records with optometry, nor an electronic eye care referral system. Respondents also highlighted crumbling and ill-equipped estates, with one unit reporting a lack of ultrasound or pan-retinal photocoagulation laser and microscopes operating at the end of life.

I am, therefore, very pleased to see this strategy commit to an in-depth review of estates, essential maintenance to clinical and non-clinical areas, an expansion of the size of ophthalmology departments, and the co-location of clinical and administrative services as appropriate. Likewise, commitments to implementing a Wales-wide EPR, networked eye care systems and a plan to replace end-of-life equipment will all help Welsh ophthalmology catch up with recent technological innovations and be well-placed to incorporate future advances.

As well as a much-needed focus on infrastructure, investment in the staff we need to deliver care is paramount. Wales has just 1.97 consultants per 100,000 population – well below the minimum three that we recommend are needed to deliver hospital ophthalmology services. As the population continues to age in the coming decades, patient demand will grow. The strategy's recommendation for an additional 36

ophthalmology training places phased over seven years will deliver the workforce needed to meet this expanding demand. We look forward to working with Health Education and Improvement Wales to put this into action.

Fully utilising primary care capacity is the other crucial part of the workforce equation. Ophthalmology and optometry colleagues already work closely in Wales, so it is right the strategy pinpoints building on these foundations as a priority. Our joint vision for integration provides a practical blueprint for how this can be achieved.

At its heart, regionalised eye care will mean working across existing boundaries to pool services and allocate resource in line with local need. While the strategy considers alternatives to such service reform to help tackle low-complexity lists, it is right to stress that without suitable commissioning arrangements our already fragile NHS ophthalmology service in Wales may be destabilised.

With our specialty's commitment to innovation and given the scale of the challenge we face, ophthalmologists in Wales are keen to do things differently and play a central role in delivering this strategy. With Rhianon Reynolds as Llywydd of The Royal College of Ophthalmologists and national clinical lead for ophthalmology as a principal author of this strategy, I have full confidence that clinicians' voices will be heard both now and into the future.

This National Clinical Strategy for Ophthalmology sets out a clear, ambitious vision for a new way to deliver eye care, underpinned by sufficient capital investment, reforming how and where we deliver care based on local need. Above all, this strategy provides a much-needed strategic direction for the development of ophthalmology services. Its ambition must be met if we are to tackle our crisis in ophthalmology. I look forward to this work developing in partnership with clinicians in Wales over the coming months and years.

Professor Ben Burton
President, The Royal College of Ophthalmologists

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Background

Our sense of sight is responsible for most of the information we absorb from the world around us. Many of the movements we perform, tasks we complete and personal interactions we make rely on vision in some way. Even our sleep schedules are affected by our visual system.

The impact of sight loss and sight impairment is substantial and affects every part of life including simple personal care tasks, socialising, and undertaking hobbies and interests. The mental health impacts cannot be underestimated, feeling of isolation, anxiety, loneliness and depression are extremely common and considerably erode quality of life for patients and their families[5].

"*I have been waiting for 2 years for my cataract's operation and during that time I've, lost independence and had to rely on others as my good eye suddenly became my bad eye and couldn't drive, watch tv or read. I feel really lonely and isolated, and I only go out when I have to"*

"*My sight has become so bad I've had to give up work and stop driving and it has really affected my ability to care for my family. I'm struggling to support my disabled father and my partner is having cancer treatment, I really worry how we'll cope if my sight gets worse"*.

"My mental health has impacted greatly on my life; I am no longer able to drive and struggling in work - can't go on much longer and worried how I can manage financially if that happens"

"I knew my mother had glaucoma but thought that I was fine. When the doctor told me I had permanently lost my peripheral vision it was devastating"

"My baby was premature but healthy. It was a shock when I heard he needed treatment for retinopathy of prematurity. I didn't know that could happen".

"I just thought I had a stye. The GP sent me to the eye hospital, and they said it might be cancer. I have had 3 operations now and now I am clear."

In recent years there has been considerable focus on transformation of primary care eye care services leading to radical and groundbreaking change that will allow optometrists to work to the top of their skill set in primary care. This trailblazing approach to eye care provision has put Welsh eyecare in the spotlight of the rest of the UK as shining example of best practice. However, the reality is that the exceptional work and effort that has been directed to primary care services cannot alone address the potential crisis in secondary care as a substantial number of patients still require the more complex eyecare provided by Hospital Eye Services (HES).

The Need for NCSOphth

It was recognised that to ensure the whole of eye care services in Wales reflect the progress made in primary care, a plan to address the known challenges in hospital eye services (HES) was needed. The ophthalmology Clinical implementation group of the planned care programme were tasked to commission the development of a National Ophthalmology strategy, this document is the start of this process.

Hospital eye services (HES) need just as radical, groundbreaking and trail blazing changes as those in primary care. This will ensure Wales has an exemplar whole eye care pathway, capable of meeting the needs of patients and growing demand over the next ten years and beyond.

Evidence is key to understand why services in Wales are not currently working and to identify possible solutions. This involves exploration of current needs and barriers to achieving change and solutions to tackle the impending crisis. Working with health boards and centrally held data, attempts have been made to accurately determine the current demands on the service and the capacity gaps that exist and are contributing to the ever-growing waiting list. Consultation with key stakeholders allowed an understanding of working conditions of those at the coalface and how transformation of care could look. Details on the processes undertaken to identify the challenges faced and the evidence uncovered can be found in the full NCSOphth document. These are similar in nature to those undertaken by the successful work carried out to develop, and now implement the National Clinical Strategy for Orthopaedic Surgery and aligned to the national Planned care strategic programme.

Challenges identified:

Currently waiting lists for HES are at all time high with an ever-growing demand.

- Epidemiology data shows that demand is projected to increase at an alarming rate over the next ten years. Continuing at the current trajectory, without urgent action, will result in an unsustainable model of eye care provision in Wales.
- *Demand growth 13 % more demand 2023/24 compared to pre covid 2019/20.*
- *Ophthalmology pathways account for 13% of all RTT pathways the highest of any one speciality.*
- *Ophthalmology follow-up outpatients account for 14% of all follow-ups the highest of any one speciality.*

Fragility of workforce.

- *At present Wales has the lowest per head capita of Ophthalmology consultants of any of the 4 nations of the UK, almost 50% of the recommendation from the Royal College of Ophthalmologists, and in Europe only North Macedonia has fewer (5),*

- *Challenges are seen in West Wales with locums and agency workforce being regularly used as they are unable to recruit to substantive posts.*
- *Training across the workforce (medical and non-medical) is variable and disjointed.*
- *The workforce survey carried out by RCOphth in 2022[9] showed that 65% of respondents planned to leave ophthalmology in the next 5 years.*
- *Contract reforms in PCES was warmly welcomed but to provide training for optometrists to deliver the extended roles, all Health Boards reported they are struggling to find the physical space to allow them to complete the training requirements and so will limit the potential of WGOS reforms*.

Serious incidents where patients have experienced irreversible sight loss due to service inefficiencies are growing and likely to continue.

- *As part of understanding the needs of the people who require our care, we have been working with third sector bodies to expand the breadth of NCSOphth. They have given us several situations where the current eyecare service has failed patients both from a delay to care causing harm, to a lack of holistic care for people living with vision loss.*

Estates and digital connectivity are considered unsuitable for purpose.

- *Capital investment in equipment is ad-hoc with many sites relying on critical diagnostic and treatment equipment that is at the end of its useful life.*
- *National Investment in digital connectivity has not delivered what was originally planned. There remains no national electronic patient record or electronic referral system that meets eyecare needs, despite previous investment and support from Welsh government and mandates from Health Inspectorate Wales (HIW). This limits the transformation capability of services, limits granular understanding of services and limits communication between HES and primary care allowing WGOS reforms to reach full potential.*
- *Since 2017, Ophthalmology is the largest outpatient patient specialty in the NHS and performs the highest number of surgical interventions. However, the historic perception of HES being a "small service" persists.*
- *H*ospital eye services estates are cramped, in a poor state of repair and space allocated has not expanded in line with demand.

Pathways of care are not always clear and consistent with marked variation across Wales.

- There is wider variance on performance against RTT targets in ophthalmology and clinical audits have also indicated wide variance in pathway management.

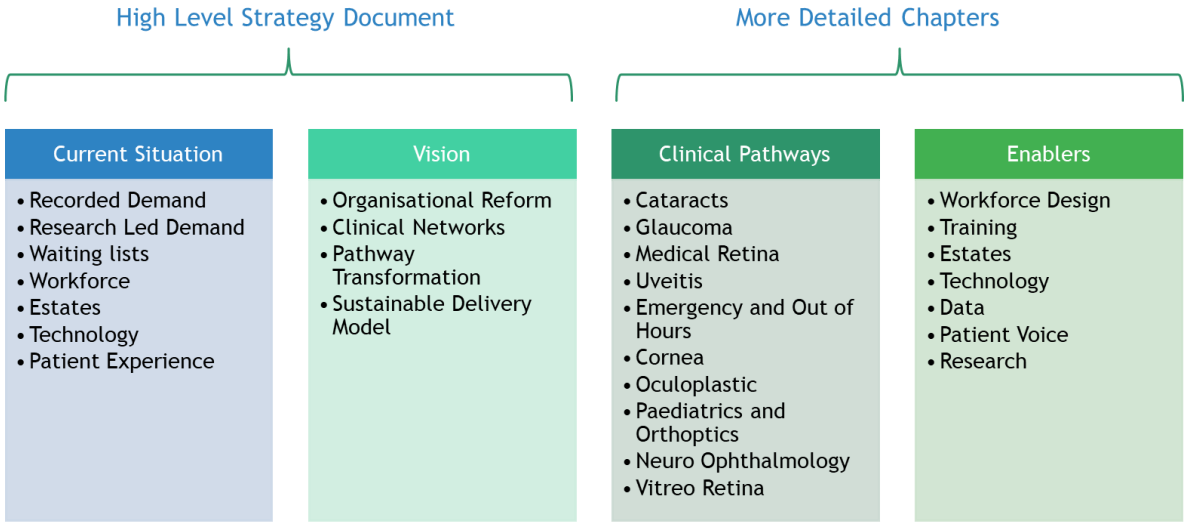
- At its best, national data allows us to appreciate the enormity of the service needs, however, planning on a Health Board or regional basis with certainty or clarity of accurate subspecialty demands, or to plan standardisation of services across Wales is not currently possible due to quality of data.
- Gaps in alignment with third sector support "The Eye Care Support Pathway" (4) a framework published by RNIB and partners to support the NHS, social care, third sector and the public to transform eye care services. We need to ensure access is available across the whole pathway where needed.

From understanding the way eyecare is currently delivered and the substantial barriers that currently exist, four main strategic themes have been developed to address this challenge head on and transform HES:

The aim of NCSOphth is to determine why the services are currently failing in Wales and set out a Blueprint for the sustainable future provision of Ophthalmology Services across Wales. This is fully aligned with the Welsh Government and NHS executive approach for the overarching National Clinical Strategy programme.

The Solution: *National Clinical Strategy for Ophthalmology* (NCSOphth)

The National Clinical Strategy for Ophthalmology is the proposed way forward for Ophthalmology Services in Wales. It provides a strategic framework to shape the clinical and support service to ensure a sustainable service in the future. Given the unexpected difficulties in extracting and analysing granular specialty and Health Board data the deliverey of NCSOphth will be in a phased manner. This report will give the strategic overlay of the blueprint for change whilst there will be a number of subsequent reports tackling the more detailed aspects of service transformation.



Strategic themes

The background work has allowed us to develop a plan which has four overarching strategic themes that will allow us to shape the delivery of Ophthalmic services. This will allow us to build a sustainable service which allows us to provide excellence in eyecare across a fully integrated pathway and retain eyecare services within the NHS in Wales, providing the best value care for our patients and ensuring those with the most complex needs will not be disadvantaged.

Organisational Reform

Maximising our workforce and culture to best care for our patients

By addressing the fundamental problems within the structure we currently work in, we can move towards organisational transformation that will ensure Ophthalmology in Wales has a culture of inclusivity and progression with a future thinking approach to patient care.

Organisational Principles

1. **Ophthalmology will be prioritised within the provision of planned care and standing commitments made to improvement in services should be honoured.**
2. **There will be commitment to the delivery of Ophthalmic services on a regional basis**
3. **Health Boards will align governance finance and priorities to a regional delivery model**
4. **There will be executive level support for regional services and the delivery of regional services will be protected**
5. **Health Board organisational development teams will work with operational and delivery teams, including clinical staff, to align to a regional model of care**

Health board commitment to Eyecare Services

Health boards are responsible for provision of eyecare services, both HES and PCES. As there are limited mortality measures associated with eyecare, services are often overlooked in favour of others. This lack of commitment and prioritising of eyecare services can lead to disengagement of clinical bodies and patients coming to harm. The commitment showed to primary care contract reform needs to be mirrored by Health Board into HES. This involves the use of Eye care collaborative groups with stakeholders from all aspects of eye care with an

Executive lead to direct service development across the entire pathway. Within secondary care, Health Board programme and delivery groups will ensure that plans for any transformation within HES are given equal standing to other services and are not overlooked. Any plans passed as executive level should be prioritised and should not be derailed by archaic ways of coal face working. IMTP's need to be aligned to the NCSOphth and directed by work within the Clinical implementation network within NHS Executive.

Regional reforms

Regionalisation of HES are fundamental to the future of Ophthalmology. There are different aspects to regionalisation of services and each needs to be considered by the regions of Wales as they progress their regional Ophthalmology work. Whilst there are small aspects of regional working underway in Wales there needs to be wholesale overhaul of the behaviour of health board as individual organisations before consideration of implementation of clinical service transformation. Without underlying governance and infrastructure in place any clinical pathways will remain fragile and ineffective. This has been demonstrated with the challenge of implementation of regional cataracts services in South East Wales which as met considerable challenges with having to navigate governance and finance of 3 different health boards to provide services. Therefore the following recommendations are made:

1. *Quality and Safety*

   Each region needs to identify the current delivery of services and where the greatest areas of risk regarding the quality and safety of services lie. This may not be the highest volume services such as cataracts but may be the more sub-specialist care that has the most marked fragility of workforce and the greatest risk for patient harm. Each Health Board in the region needs to agree on a regional strategy for addressing these risks.

2. *Service sustainability*

   In order to be sustainable the service needs to agree a regional ophthalmology budget which is ringfenced and pooled with a central finance governance not dependant on individual Health Board constraints. Where there are multiple HB operating within the region consideration should be given to solutions to address these issues such as requests for the establishment of statutory regional organisations, and single employer approaches.

   Workforce needs to be reviewed and aligned to a regional model of care. Organisational development departments will be central to this move in culture for often siloed workforces. There needs to be cultural shift at all levels to thinking of Ophthalmology as a regional service and it needs to be integral to all future service delivery. There needs to be a review of job planning and employment to ensure consistency across the region to allow interchangeable consultant level workforce across the region and services to be delivered on appropriate site. Non-medical workforce and operational workforce need to have alignment of job descriptions to allow a mobile workforce to address needs on a regional rather than Health Board basis. Clinical leadership is essential; proper time and consideration must be given ensure the highest clinical standards are met.

3. *Delivery*

   Delivery of regional services need to work from a centre where complex and specialist services are delivered. This will be the highest level of skilled care provided by tertiary

teams for each of the sub-specialties within Ophthalmology. There needs to be a network of more local units which can deliver less complex care closer to home, this may include high volume low complexity hubs to provide cataract services. along with diagnostic and treatment hub within the community supported by the extensive primary care eye services.

Workforce Principles

1. **A cross professional workforce plan will be developed to address current gaps and future projections. Succession planning is critical.**
2. **Fully job planned multidisciplinary and multi professional teams with formal recognition of clinical and service development roles will exist within every unit in Wales.**
3. **The importance of training will be recognised with dedicated time to provide high quality training for all members of the wider Ophthalmology team. Training will be protected and prioritised.**
4. **Non-medical clinicians will work to a standardised competency framework across Wales for shared roles.**
5. **Hospital optometry departments will be developed in every unit to support HES and integration of primary care optometrists in sessional roles.**

Medical workforce

The Clinical Implementation Network (CIN) will work with clinical leads and Health Boards to ensure consistent job planning of current consultants. There is variation across job planning rules across employers and this needs to be addressed as part of a wider sustainable approach. Training of Ophthalmic trainees must continue to be the priority of the consultant body along with the introduction of formal Ophthalmic Local Training (OLT) with particular emphasis in locations traditionally difficult to recruit into. Doctors of all levels will commit to the training and support of non-medical workforce, but this cannot be to the detriment of the medical training experience. Very strict guidance exists from the GMC and RCOphth on training medical workforce and if these are not met training grade doctors can be removed from units. The investment from Welsh Government in a state of the art simulation suite in Cardiff University demonstrates that commitment can be made and should be of a recurrent nature.

According to RCOphth workforce survey, 65% of respondents in Wales planned on leaving the workforce in the next 5 years. Many of these will be a planned retirement. It is paramount that units work to identify upcoming changes at the earliest opportunity and work on a regional basis to ensure units are not left with large medical workforce gaps. Health Boards must work collaboratively with each other and with the Ophthalmology teams to advertise posts in a timely manner to maximise potential recruits.

Without these changes HES in Wales will continue to be dependent on locum posts which do not provide a sustainable approach or investment on transformation of service delivery. In turn the medical workforce will commit to change and new ways of working to meet demands as well as giving a commitment to maximise productivity.

Non medical clinical workforce

Across Wales there is a marked variation in the way the non-medical workforce works in HES. By creating a multi-professional sub-group of the CIN we will work to ensure that the non-medical workforce work to a competency based framework to deliver care. A future workforce will maximise the Multi Professional approach, sharing skills and experiences to maximise patient care. An agreed Wales wide best practice model for optimum MDT working will be developed and implemented. All clinical staff will work to top of their registration and non-registered practitioners enabled to take on roles as recommended by the RCOphth and GIRFT.

Operational workforce

The operational team, and particularly those who hold administrative roles are often overlooked in terms of delivery of care. High quality care can only be delivered where there are close working relationships with the non-clinical members of the team. Co-location of service enhances this relationship and provides a more cohesive working environment and contributes to a more effective way of working.

Case Study

Creative ways of maximising the workforce and enabling practitioners to work at the top of their licence have been introduced within Swansea Bay University Health Board. A multi-professional approach has been implemented that blends the skills and abilities of Orthoptists, Hospital Optometrists, and the registered and non-registered nursing professions. Considering functions rather than traditional roles has modernised the workforce structures and created additional training and development opportunities for the non-medical staff that has also increased morale and retention in the service.

Clinical Networks

All Wales Clinical Networks to deliver the highest quality evidenced based care and ensure equity across the Nation

Welsh Ophthalmology has a history of engaged clinicians striving to make service and system changes for the benefit of patients. By building on this and expanding networks across the integrated pathway and to include non-medical clinicians we can ensure equality of care and equity of access for all patients in Wales.

Clinical reference groups

1. **Develop clinical reference groups for each sub-speciality within Ophthalmology**
2. **Strengthen links across PCES and HES**
3. **Agree nationally on best practice and undertake benchmarking**
4. **Ensure practice is evidence based and clinically led**

Clinical reference groups

Ophthalmology has 9 distinct subspecialty areas:

- Medical Retina and Uveitis
- Glaucoma
- Oculoplastics
- Paediatric Ophthalmology
- Cornea
- Cataract
- Emergency Eye care
- Neuro-Ophthalmology and Adult motility
- Vitreo-Retinal services

Within each of these there are distinct evidence examples of best practice. The Clinical Reference Groups (CRG) will review the evidence base and develop all Wales pathways of care, Welsh National Clinical guidelines and steer the work of the CIN in specific sub-specialty areas.

Specific details around sub-specialty working was expected to be part of the initial NCSOphth delivery however, considerable barriers around coding and data collection within Health Boards has meant that this has not been possible. The CRG's will be able to understand the granularity of requirements for delivering a high quality and effective clinically led service. By agreeing a national approach to the most common aspects of sub-specialty care we can ensure that patients across Wales are getting equal quality of care whilst ensuring that a this is being delivered in the most cost-effective manner without compromising standards.

The clinical reference groups will also act as subject matter experts in the ongoing integration of primary and secondary eye care. By building close working partnerships with Optometric colleagues, including the WGOS National Clinical leads the CRG's can ensure that the high standards expected from secondary care services are translated into the expansion of enhanced optometric services in primary care.

Case study

During the development of the Wales General Ophthalmic Services (WGOS) pathways that underpin the Optometric contract reform WGOS National Clinical Lead have worked closely with medical retina and glaucoma Clinical Reference Groups. This has contributed to the development of the WGOS handbooks and minimal data sets expected for WGOS 4 to be delivered in the community. This has ensured that the same exacting standards expected when patients attend Hospital Eye Services are translated into Primary Care Eye Services and there is no disadvantage for patients being seen via WGOS pathways.

MDT working

1. **Empower non-medical clinicians to achieve their potential**
2. **Standardise training and competency recognition across Wales above local constraints**
3. **Enhance and promote the multi-professional team throughout the Hospital Eye Services (HES)**
4. **Explore novel and innovative approaches to delivering care outside of the traditional consultant delivered model of care**

There is simply not enough ophthalmic medical workforce to meet the demand in Wales. Whilst strategies will be undertaken to address this shortfall, the worst in the UK, the opportunities for multiprofessional working cannot be underestimated. Within HES there are a number of non-medical clinicians that have traditionally been part of the workforce. This includes nursing, optometry, orthoptics, ophthalmic technicians and imaging services. In a traditional model of care these would provide support to a consultant delivered service which draws of core competencies of individual professions.

This is an extremely inefficient way of working. It limits not only the number of patients that can be seen within a service but also limits the potential of the workforce. There are a number of established enhanced roles within HES in Wales such as the use of non-medical injectors for macular degeneration services but the provision of more innovative use of skills is patchy and often limited by local governance constraints that are not always pertinent to ophthalmic services.

By accessing training and support many non-medical clinicians could be skilled to undertake a significant proportion of the service deliver in HES and move the service away from a traditional consultant delivered model of care to one that is consultant led. By standardising training, ensuring equity of access across Wales, and moving towards true competency and skills-based working rather than labelled professional constraints.

Developing an all Wales Multi-Disciplinary Team Clinical Reference Group will allow us to move towards this goal.

Patient engagement and third sector partners

1. **Centralise care to patient need and expectations**
2. **Work with third sector partners across Wales to ensure NCSOphth maintains the patient at the heart of transformational change**
3. **Work with PECS to ensure that patients moving into community-based care are not disadvantaged**

When looking at the enormity of healthcare provision, the patient and their needs can be overlooked. When faced with huge numbers on pages and ever growing graphs it is sometimes easy to forget that each of those numbers is a person and their care is on our hands. The patients who access eyecare can have very specific accessibility needs that cannot be ignored. Vision impairment can limit independence and the use of drops that blur vision in examinations mean that patients cannot drive themselves to appointments and so are dependent on other means of transport. Moving care from HES to PCES can also raise concern in patients. Furthermore, established vision support services within secondary care currently have a limited presence in PCES.

It is therefore vital that patient groups are key to each of the clinical networks that are developed to provide information about the patient needs and priorities. This is a collaborative approach and the close working partnership will also help patients to understand planned transformation of services and the potential need for them to access services differently. More information can be found in Appendix 4

Pathway Transformation

Ensuring pathways across the entirety of the patient journey provide seamless integrated care delivered to nationally agreed standards

The implementation of pathways across eyecare will ensure that patients receive equality of care across Wales. There are multiple resources to allow seamless delivery of care across the whole integrated eye care pathway. This will ensure that no matter where a patient is in Wales they can expect the same standard of care and support.

Secondary care pathways

1. **Recognised UK guidelines including GIRFT and RCOphth will be adapted to delivery in a Welsh healthcare system.**
2. **Standardised pathways will be expected to be implemented across Wales to deliver expected best practice and efficient care**
3. **Implementation of clinically agreed pathways will make data collection, analysis and comparison more accurate to allow for planning of services.**

There are several UK recognised recommended pathways including those provided by Getting It Right First Time (GIRFT) and RCOphth. These are generally developed for use within NHS England and will require review and adaptation to NHS Wales. Furthermore, it is important to understand that the delivery of efficient pathways relies on well-functioning infrastructure and implementation of pathways is unlikely to be successful without the organisation reform discussed previously. Each of the Clinical Reference Groups will develop sub-specialty specific pathways that will be agreed nationally and implemented regionally.

Cataract services

Delivery of cataract services in Wales is an example of how lack of efficient pathways coupled with operational challenges have led to an all-time high waiting list for care. Efficient cataract services as outlined by GIRFT rely wholly on pathway design and implementation. Whilst there is an element of adaptation by the medical workforce to high volume working, without clear pathways in place a high-volume service can never be achieved. The patient journey begins when

referred from primary care. A robust pathway from the outset will ensure the patient is seen in a single pre-operative visit by an appropriate clinician where all paperwork needed including patient consent and lens choice is made. Admission for surgery is within 6 weeks to limit potential adjustment to surgical needs. On admission al paperwork is present and admission protocols are in place and followed allowing the surgeon to proceed with limited adjustment to plans. Following surgery, the patient is discharged with post operative follow-up being carried out in the community by PCES. For this apparent simple pathway to work there are numerous administrative steps and departments to facilitate the smooth running of the pathway. Without organisational reform any pathways will struggle in implementation.

Integrated Eye Care

1. **Work to break down barriers between primary and secondary care to deliver a fully integrated eye care service across Wales**
2. **Recognise the need for robust integrated pathways to maintain clinical governance**
3. **Integrated eye care pathways are delivered on a regional basis**

Eye care in Wales should move towards a fully integrated service with barriers between secondary and primary care removed for the delivery of NHS eye health services. In time this may lead to the development of a standalone eyecare division in operational services with pooled resources, budgets and governance. Progressing this ideal will require close working with colleagues in PCES to ensure that whole pathway systems are established to allow seamless transition of care. As PCES provide greater numbers of enhanced services this robust pathway governance becomes essential to providing safe and effective care. Pathway development also allows up to benchmark care and ensure that there is consistency in those providing care.

Integrated Eyecare also encompasses the support services needed by patients with visual impairment. People living with sight loss have very complex needs and those needs should be integrated into the end-to-end pathways of care.

Sustainable Delivery Model

Sustainable regional delivery of an integrated eye care pathway

The future of Ophthalmology in Wales can only be delivered on a regional platform. By maximising current resource and investing in future delivery of care Ophthalmology can move towards a position of strength in NHS Wales.

Estates

1. **Optimise current resources across regions**
2. **Centralise complex care in Ophthalmic specific estates and provide less complex care closer to home**

The current estates available to Ophthalmology services in Wales will be optimised to deliver rapid improvement sin care, however this alone will not be sufficient to address the significant demand and capacity shortfall that exists.

Hospital buildings are a significant constraint to the way services are delivered. They control the amount of activity, size of workforce, efficiency of flow, and the opportunities for change and service improvement. Working spaces and environments can significantly influence the way staff and patients feel about services. In every unit physical space is a considerable limiter to the successful delivery of current services. With the proposed expansion of the workface to tackle demand, the already constrained space will limit the potential these changes can deliver.

There cannot be any doubt that the future of Ophthalmology is regional delivery. The model of care to be adopted is central complex care supplemented by local routine HES and supported by PCES. Location of central services should be scoped appropriately but will require co-location with other secondary care services due to common interdependence of care in complex conditions. This will likely lead to self selecting sites in Swansea, Rhyl, and Cardiff. The use of current Ophthalmology sites for the delivery of central complex services is impossible. Current estates are, at very best, fit for partial delivery of local routine HES. Investment is needed in development of all sites however, moving complex care, to a central solution and moving high volume low complexity (HVLC) care out of routine delivery may reduce demand on local sites and subsequently reset the capacity need more aligned with current availability of estates.

However, commitment and investment is needed in the development and delivery of the remaining aspects of the model. Central hubs need to be fit for purpose, large enough to accommodate need, at the forefront of technology and advanced clinical care with enough space to train medical and non-medical colleagues and to allow predicted expansion of demand.

HVLC centres need to meet population demand and do not need to sit within acute care services and can be stand alone units. Within Ophthalmology HVLC includes routine cataract care and routine intravitreal injection services. Cataract care is a once or twice contact episode and patients may be willing to travel to receive care, however injection services require frequent attendance and the burden of travelling extended distances on a regular basis (can be monthly or 6 weekly) is unacceptable. Therefore different models for delivery need to be adopted for these aspects of care.

Digital strategy for Eyecare

1. **Roll out of fully integrated ophthalmology specific electronic patient record accessible in both PCES and HES**
2. **Roll out eye care specific electronic referral system**
3. **Roll out of Image sharing platforms allowing ophthalmic imaging data to be shared across PCES, HES and Health Board sites**
4. **Effective data capture to enable accurate coding and booking**

Electronic Patient records

Digitalisation of eye care is fundamental to the delivery of transformational eye care services. Wales is behind the other UK nations with no fully functioning Electronic Patient Record (EPR) in any unit in Wales. Bespoke Ophthalmology EPR allow proper transformational change to occur. Previous attempts to implement an All Wales EPR have stalled due to various reasons and was moved into DHCW for delivery. However due to difficulties with contracting after a year of taking on the project the roll out of an EPR still hasn't been implemented. The current EPR underwent procurement processes following commissioning from DHCW and it remains the solution of choice for Ophthalmology in Wales and should be delivered at speed. The investment to this point in both finances and time must be recognised and any direction away from the original agreement should not be considered. Individual views from single clinicians should not be prioritised above approval from the national framework that now sits in place to drive Ophthalmic services in Wales. Unfortunately as this programme sits in DHCW the remit for this outside of the Clinical Implementation Network (CIN) for Ophthalmology. NCSOphth sees the delivery of an Ophthalmic EPR as an urgent priority.

Digital referral

A HealthCare Inspectorate Wales (HIW) review in 2016 highlighted the absence of digital referrals into secondary care as a significant governance risk and mandated the implementation of a digital referral system between PCES and HES. Eight years later there is still no functioning e-referral system in Wales. In addition to EPR, NCSOphth requests the urgent delivery of an electronic referral system in every unit in Wales.

Service data

By simplifying the coding used for Ophthalmic conditions, clinic codes and templates, data services within Health Boards can provide accurate demand data with the granularity required to design future services. By working with the coding and operational teams a standard approach to coding across Wales should be implemented.

Training and research

1. **Increase Ophthalmology training places in Wales to align with RCOphth guidance**
2. **Implement Ophthalmic Local Training across Wales to empower non-run through doctors to achieve their potential via portfolio registration**
3. **Research will be integral to Eye care in Wales in primary care, secondary care and University settings**

A Sustainable future for Ophthalmology can only be achieved by investing dedicated time and resources into the training of the next generation of workforce. This is true for all levels of clinical and non-clinical staffing and will underpin the success of this blueprint. However, training of Ophthalmology trainees must be prioritised and must not be compromised by additional staff training requirements. Each Health Board will develop a plan on how they can meet the training needs of the department and a should have a dedicated Ophthalmic practice educator that is responsible for Ophthalmic specific training across the MDT workforce. Profession specific training should come under core standards of care.

Developing a Welsh Ophthalmic Local training (OLT) programme to allow doctors who are not on a formal training programme will be a huge attraction of workforce into Wales. The national recruitment of Ophthalmic trainees is one of the most competitive recruitment programmes in medicine and there are many who are not successful in securing a place or who have prioritised

remaining in Wales above the possibility of having to move elsewhere in the UK to take up a training post. By developing an OLT that can be delivered on a regional footprint would increase the attractiveness of Wales as a place to work and address the current workforce crisis that exists.

Case Study

Welsh Government invested £750,000 in the development of an Ophthalmic simulation suite situated in the School of Optometry and Vision Science in Cardiff University. This is the most sophisticated simulation suite in the UK and has been approved to host RCOphth surgical skills courses

Research

Research is fundamental to the future of eye care. In Wales, with the exception of Cardiff and Vale UHB, there is a poor tradition of clinical trials being undertaken in secondary care in Wales. Working with the new National Institute for Health and Care Research (NIHR) goals to target areas previously under-utilised for trial delivery we can expand the opportunities for our patients to access cutting edge clinical trials.

Primary care has also often been an area where research is undertaken sparsely however with the recent changes, the opportunity for research in primary care has never been greater. Working across boundaries the integration of research priorities and goals is achievable.

We are fortunate in Wales to have world-class cutting-edge Vision Science research institution in Cardiff University, advanced clinical research and health economics in Swansea University and qualitative and social care research in the Universities of South Wales and Bangor. Stronger relationships will be built to ensure that patients and clinical workforce can have the opportunity to take part in such work. Collaborations across clinical networks can only strengthen the quality of research being carried out in Welsh Universities.

Requests

In order to drive forward transformation at speed immediate requests are made from our partners to support this development work;

Welsh Government:

- **Provide leadership and alignment of integrated eye care services across planned care and primary care policy and drive forward the full regionalisation of Eye Care in Wales by requesting performance and targets are met on a regional NOT health board basis. This will ensure Health Boards reconfigure their approach to HES to a regional challenge.**
- Promote and utilise the role of the National Clinical Lead for Ophthalmology, to drive strategic delivery across Wales using evidenced based clinical best practice.
- Establish or dedicate the role of a non-clinical National Director for Ophthalmology in NHS Wales Executive to demonstrate the specific focus for this clinical area and the transformation requirements set out. This role would also align, work with and support further enhancement to regional working in eye care across Wales, and ensure assurance from health boards on their commitment to improvement.
- To prioritise and fast track the implementation of an electronic patient record (EPR) via DHCW 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, and to ensure solutions are clinically led not based on cheapest or easiest options to implement.

Welsh Government is requested to endorse NCSOphth and make a firm commitment towards supporting the strategic ambitions for Ophthalmic Regional Services in Wales both through a policy driven and investment approach.

Health Boards:

- **Commit to true regional delivery mechanism for services in Wales, working without boundary constraints and as a single body.**
- **Actively participate in recommendations from NCSOphth and Clinical Implementation Network (CIN).**
- **Actively facilitate change and remove barriers towards improvements within secondary care Ophthalmology services.**
- Prioritise Ophthalmology Services within the annual planning cycles.
- Honour commitments already made to local and regional solutions and drive transformation ahead with urgency.

- Work with the current clinical workforce to maximise productivity and minimise variation in service delivery by implementing the clinical and management best practice recommendations.
- Increase and improve physical capacity and estates of Ophthalmology in secondary care wherever possible and not to downgrade the urgency of such needs.
- Improve recruitment into secondary care eye care services and fund the expansion of the consultant workforce in line with RCOphth guidelines and recommendations and in line with a regional workforce plan.
- Provide data analysis support to Ophthalmology departments to ensure data and coding is robust and accurate information is available to manage the services.

HEIW:

HEIW has already shown commitment to the future of Ophthalmology training in Wales by advertising the first Head of School for Ophthalmology

- We ask for HEIW to support the expansion of the Ophthalmology training workforce according to the Royal College of Ophthalmologists (RCOphth) recommendations and work with operational teams and current medical workforce to accommodate the increased training needs.
- To consider non-medical eye care as a separate department within HEIW. Whilst there is an optometric lead, other professions fall into generic groups such as nursing who often are unaware of the differences in requirements in Ophthalmology specific training. Bringing all the professions together under a single eye care umbrella would cement the equity of access to training for all professionals that work in eye care as well as those who are un-registered but committed to undertaking further study in this very specialised area. This upskilling of our core workforce is integral to the success of NCSOphth.

NCSOphth Next Steps

To secure the future of Ophthalmic services adoption of this strategic view is fundamental to the delivery of a high quality, sustainable, integrated Eye Care Solution in Wales.

Going forward commitment is required to shape the detailed plans for the future as well as implementing transformational change that can start immediately.

This is the first high level strategic overview of the blueprint for transformation of Ophthalmic services. This initial report will be followed by a number of more detailed reports each looking at a focussed aspect of the delivery of HES. The planned reviews include:

- **Sub specialist reports and strategy**
    - Each of the sub-specialities will develop standardised pathways across Wales to ensure equality of care and equity of access for all eye conditions. These are:
        - Medical Retina and Uveitis
        - Glaucoma
        - Oculoplastics
        - Paediatric Ophthalmology
        - Cornea
        - Cataract
        - Emergency Eye care
        - Neuro-Ophthalmology and Adult motility
        - Vitreo-Retinal services
- **Workforce, training and research:**
    - A detailed workforce analysis and the development of a formal workforce strategy looking at medical and non-medical workforce, training and the needs surrounding this and the integration of research into Eye care in Wales
- **A digital strategy for eye care in Wales**
    - A full review of the way digital services can be integrated into care pathways to optimise the efficiency and effectiveness of services. This will include ophthalmic electronic patient records, digital referral systems, image sharing solutions as well as integration of wider operational digital solutions.
    - Detailed analysis of current demand and capacity issues will be attempted, however it is unclear if the granularity of data to carry out this with accuracy exists within the NHS in Wales. The clinical reference groups that will be established as part of the CIN will drive this element of the strategy to deliver the best evidence based quality of care across Wales and eliminate unwarranted variation.
- **Patient centred care**
    - Fundamental to care is ensuring that all transformation is patient centred and delivering to patient's needs. We have a close working relationship with patient groups and third sector partners including Wales Council for the Blind, Sight

Cymru, RNIB and many other national and local organisations. We will work alongside them to ensure full equity for patients when services are being designed and developed and to ensure that services across planned care are fully accessible for those with visual impairment.

Ophthalmology Clinical Implementation Network (CIN):

The Ophthalmology Clinical Implementation Network (CIN) is the vehicle for delivering the strategic aims of NCSOphth. However, it is in its infancy, and further resources are required to support its growth to deliver the future vision for Ophthalmology.

The principle aims of the CIN in the first 18 months will be:

- a focus on establishing clinical reference groups (CRG's) for the three highest volume services in secondary care; Medical Retina, Glaucoma and Cataract services and working towards standardisation of care across Wales.
- Nurture and grow the current multiprofessional workforce CRG and work with the patient communications subgroup to ensure accessibility in healthcare for patients with visual impairment.
- Develop a set of clinically lead metrics to allow meaning full outcome assessment of secondary care services.
- Work with other CIN's and the theatre optimisation team to address under use of current surgical capacity.
- Drive the WGOS reforms from a secondary care perspective and strive for them to realise their potential in the future of integrated eye care.

The formal programme will require adequate resources to take forward this substantial programme of work. This includes administration, planning and delivery teams dedicated to Ophthalmic transformation without distraction from commitment to other services.

Conclusion

There can be no doubt that the state of hospital eye services in Wales are currently at a tipping point. If nothing is done services will quickly reach crisis point, and patients in Wales will continue to come to harm from lack of access to expert services. However, change can be effective. There has been a groundbreaking move to provide eye care in Wales with a primary care service, the first in the UK and a support for hospital eye services that has never before been available. Whilst this will help with patients who are at lower risk of vision loss we now need to focus on the higher specialist care provided by secondary care services.

Evidence collected by this report has shown that there is a problem with collecting accurate data to measure services, with marked variation across Health Boards which limits ability to plan services and compare activity. Estates are not fit for purpose and too small to provide modern hospital eye services. There is no useful digital solution and roles and job plans are varied and disparate across Wales and clinicians have disengaged from change.

Building on this evidence a solution has been developed that provides a blueprint for the future delivery of Ophthalmic services in Wales. The National Clinical Strategy for Ophthalmology clearly lays down the groundwork needed for sustainable transformation of HES. The only future for Ophthalmology is true regional delivery of secondary care services. This is not a nod towards collaborative working but a true regional model of care with specific governance finance and planning in place. This can be rapidly facilitated by a move towards requiring Ophthalmology targets and plans to be delivered regionally and not within Health Board targets and boundaries. As this organisational reform takes place it will facilitate the move towards centralised highly specialised care that is supported by local delivery of less complex cases. Clinical networks and pathway changes will be evidence based, robust and peer reviewed to ensure equality of care and equity of access across Wales as we move towards a sustainable delivery model for the future. Investment will be needed, but this is not limited to financial investment. Time and commitment from all stakeholders is essential to facilitate change and must be integral to the solution.

The Clinical Implementation Network (CIN) will work with frontline operational teams to work towards delivery of many of the asks of NCSOphth but requires the support and leadership of Welsh Government to mandate change, and the executives of Health Boards to commit to an entirely different way of working. Without this the plan will fail, but with it, eyecare in Wales will become a gold standard in a fully integrated eye care service that cares for every person, at every level.

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