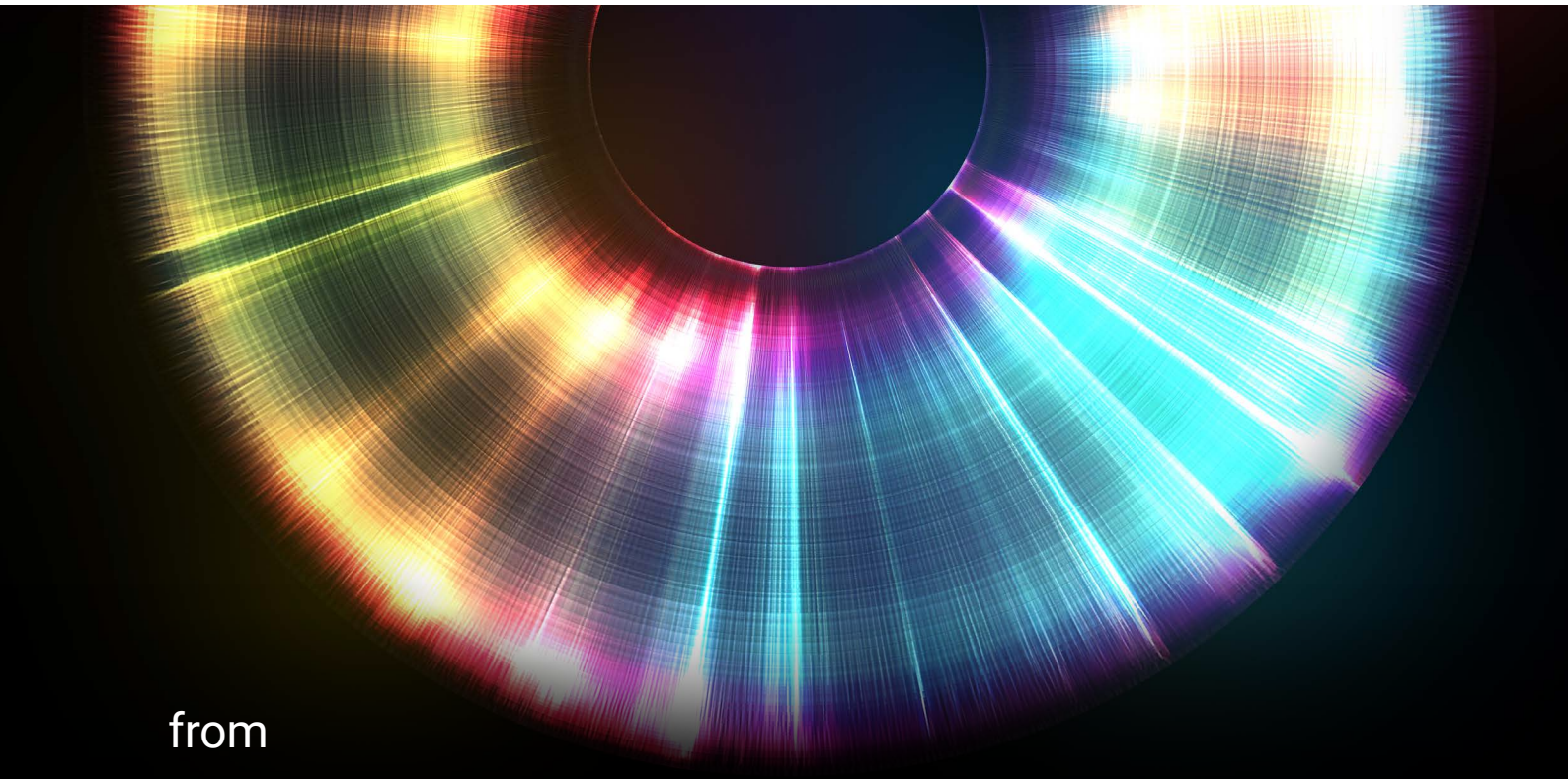
Protect Sight

A national eye care network for Wales

A proposal to the Welsh Government following the Senedd Cymru, Health and Social Care Committee, Inquiry into Ophthalmology Services in Wales



from

SpaMedica

Foreword

Every week in Wales, people lose sight they did not need to lose. Not because the NHS does not know how to treat them, and not because the treatments are unaffordable, but because the capacity to treat them in time does not exist where they live.

The Senedd's Health and Social Care Committee examined this problem thoroughly last year. Its conclusion was clear: short-term funding has not fixed it, and will not. What Wales needs is permanent capacity, built to last, planned nationally and delivered locally.

This document is our answer to that conclusion. It is an offer to put our own capital at risk to help build a national eye care network for Wales, to a specification set by Welsh Government, at NHS prices, won in open competition. This is a cost neutral offer for NHS Wales. Activity will be funded on a per episode basis, no front-loading of capital or spend from NHS Wales. Faster access, no additional spend. If another provider can meet that specification better than we can, Wales still gets the network. That is the point.

We have treated many thousands of Welsh patients, in Wales and across the border. We would rather treat them in Wales. This proposal sets out how.





Richard Woodward

Chief Executive Officer
SpaMedica

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The offer in brief

SpaMedica is offering to invest up to £20 million of private capital in a national, multi-specialty eye care network for Wales — built to a specification set by Welsh Government, delivered to NHS Wales standards and prices, free at the point of use, and won through open competition. This is a cost neutral offer for NHS Wales. Activity will be funded on a per episode basis, no front-loading of capital or spend from NHS Wales. Faster access, no additional spend.

The network we would bid to deliver:

- **Five Welsh eye hospitals** — including expanded capacity at our existing Swansea hospital — delivering cataract, glaucoma, medical retina, oculoplastics and selected vitreoretinal surgery.
- **A national network of outpatient and diagnostic centres**, giving people local access to outpatient appointments, pre-operative assessment and post-operative review, glaucoma monitoring and treatment, wet AMD injections and diagnostics — with the number and locations determined by the specification and by travel-time modelling.
- **A mobile eye hospital** on a published rota, deployed first and serving rural Wales permanently.
- **Up to 175 new Welsh healthcare jobs and up to 80 training placements a year,** recruited without drawing staff from health board teams.
- **Free patient transport** as standard, as we already provide from Swansea.

What it would achieve:

- Around 92% of people in Wales within 30 minutes of expert outpatient eye care, and almost everyone within 60 minutes of a sight-saving hospital.[1]
- Waits on suitable ophthalmology pathways brought within target and held there.
- Routine and sub-specialist activity repatriated from England, keeping Welsh funding, jobs and training in Wales.
- NHS consultant sessions and theatre time released back to the complex care only hospitals can provide.

What we are asking for:

Not a decision about SpaMedica. We are asking Welsh Government to run a formal market engagement exercise on a multi-year, multi-specialty ophthalmology network, and to consider that network in the National Clinical Services Plan and the surgical hubs programme. Welsh Government sets the specification; providers compete to meet it.

[1] Access figures are working estimates and would be confirmed by formal travel-time modelling, weighted to population at small-area level with a public transport overlay.

1. The case for action

The Senedd has already made it

In November 2025, the Senedd's Health and Social Care Committee concluded its inquiry into ophthalmology services in Wales. Recommendation 10 of its report calls on the Welsh Government to commit to a multi-year, ring-fenced investment programme for secondary eye care — supporting a sustainable regional model, estate upgrades, equipment replacement, and workforce expansion and retention — matching the scale and ambition of the recurrent funding already provided to reform primary care optometry.[2]

That investment has not yet been made. The previous Welsh Government accepted only two of the Committee's seventeen recommendations in full, and the Committee has since requested a supplementary paper on the absence of immediate measures.[3] The Committee's own conclusion was that ad-hoc, short-term support has not enabled long-term, sustainable improvement. The new Programme for Government, published in September 2026, now sets the direction: up to ten surgical hubs across Wales, stronger national clinical pathways with ophthalmology named among the priorities, and a National Clinical Services Plan to carry them.[4] This proposal is one way of delivering that commitment for eye care — within the planned NHS Wales budget trajectory, and without waiting for capital that is already spoken for elsewhere.

The scale of the problem

Ophthalmology is the single busiest outpatient specialty in the Welsh NHS. More than 1 in 20 people in Wales are waiting for an ophthalmology appointment — around 1 in every 8 patients on the entire NHS Wales waiting list.[5]

Delays matter here in a way they do not in every specialty. In glaucoma, wet AMD and diabetic eye disease, sight lost while waiting does not come back.

In July 2026, 158,300 patient pathways in Wales were assessed as being at highest risk of irreversible harm; 79,621 of them — 50.3% — were waiting beyond their target date. That is almost exactly the position the Committee reported for January 2025, and the figure has not moved outside a band of 76,000 to 82,000 in any month since. No health board is achieving the national standard of 95% of the highest-risk patients seen within target; the best is at 91%, the worst at 38%.[6]

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[2] Senedd Cymru, Health and Social Care Committee, Inquiry into Ophthalmology Services in Wales, November 2025 (CR-LD17590), Recommendation 10.

[3] Welsh Government response to the Committee's report, and Senedd Research, 'Vision without focus: is the Welsh Government missing the urgency on ophthalmology?', February 2026.

[4] Welsh Government, Programme for Government 2026 to 2030: New ambition for Wales, Chapter 1: Building a health and care service fit for the future, and cutting waiting lists, published 10 September 2026.

[5] National Clinical Strategy for Ophthalmology, 'Delivering the Future of Ophthalmology in Wales', NHS Wales Executive, September 2024; cited in the Committee's report at paragraph 26.

[6] Welsh Government, Eye Care Measures for NHS outpatients, July 2026 (StatsWales, 'Patients waiting for an ophthalmology outpatient appointment', published September 2026). Figures relate to Health Risk Factor R1 pathways with a target date allocated; 'beyond target date' means beyond the target date plus the 25% tolerance used in the published measure. January 2025 comparison from the same series, as cited in the Committee's report at paragraphs 9 and 83.

1. The case for action

Demand is rising and broadening. The number waiting for an ophthalmology appointment rose 169% over the past decade, and demand in 2023/24 was 13% above pre-COVID levels. The Royal College of Ophthalmologists estimates demand will rise by a further 40% over the next 20 years.[7] More than 111,000 people in Wales already live with sight loss, a number RNIB Cymru expects will double by 2050.[8]

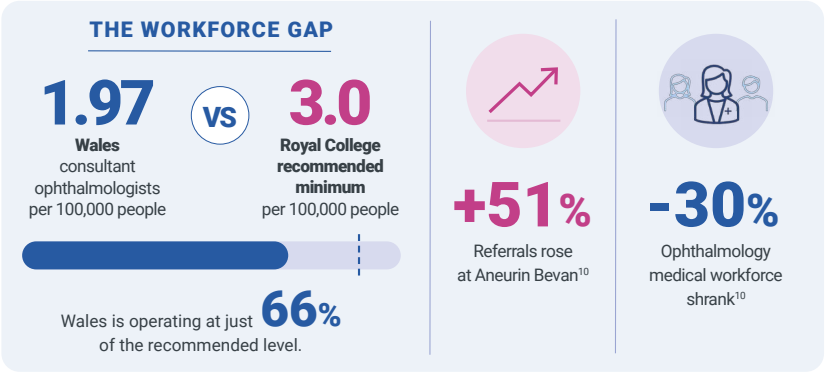
A workforce that cannot absorb it

Wales has 1.97 consultant ophthalmologists per 100,000 people — 62 full-time equivalents in 2023 — against the Royal College's recommended minimum of 3 per 100,000.[9] At Aneurin Bevan, Audit Wales found referrals rose 51% while the ophthalmology medical workforce shrank by around 30%.[10] NHS Wales cannot ask a shrinking consultant body to absorb rising demand. Any credible answer has to add workforce, not redistribute it.

Why buying activity has not worked

Additional investment by Welsh Government has seen more people treated over the past year, and we welcome it. But as Rhianon Reynolds, Llywydd of the Royal College of Ophthalmologists in Wales, told the Committee: "You can clear the waiting lists, but unless you do something to stop those waiting lists building up again in a few years' time we're going to be in exactly the same situation we are in at the moment."[11]

Short-cycle funding buys activity. It cannot buy the permanent estate, equipment and workforce the Committee concluded Wales needs — because no provider, NHS or independent, can invest against a twelve-month commitment. A multi-year specification changes that arithmetic. That is the single mechanism this proposal turns on.



> **Any credible answer has to add workforce, not redistribute it.**

[7] National Clinical Strategy for Ophthalmology, September 2024, cited in the Committee's report at paragraph 18 (decade rise) and paragraph 26 (13% and 40% figures).

[8] RNIB, 'more than 111,000 people in Wales living with sight loss' (rnib.org.uk/nations); RNIB Cymru, 'By 2050, the number of people with sight loss is expected to double'.

[9] National Clinical Strategy for Ophthalmology, September 2024, cited in the Committee's report at paragraph 26; and Welsh Government, Ophthalmology Summit report, 14 October 2024 (62 FTE consultants in Wales in 2023).

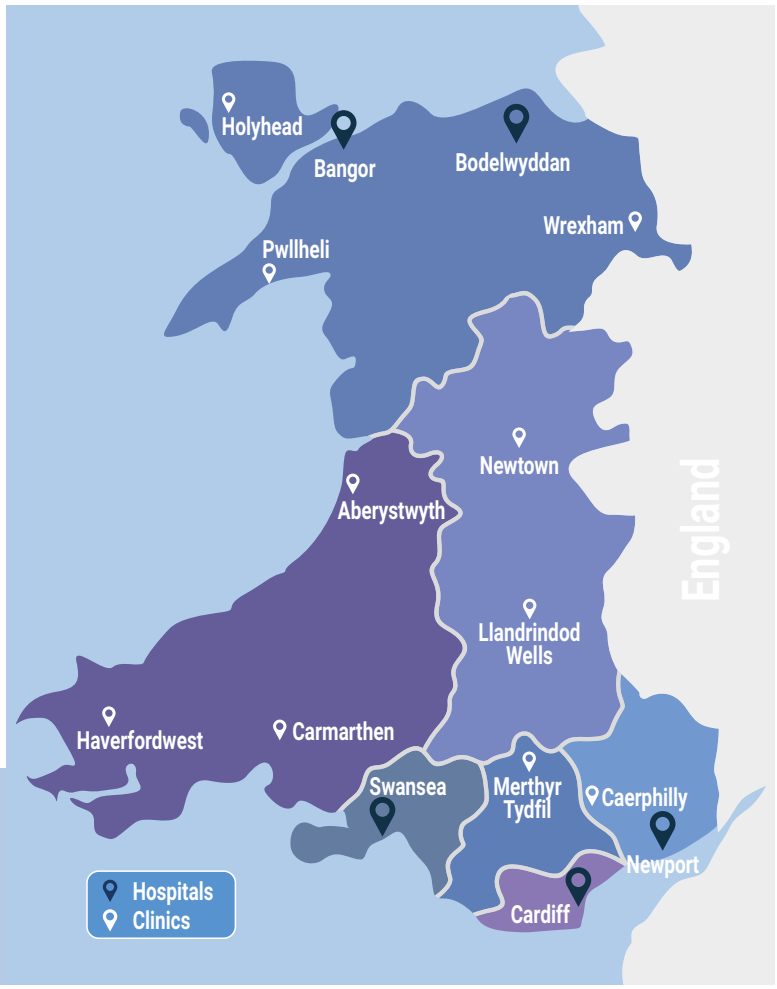
[10] Audit Wales, Eye Care Review – Aneurin Bevan University Health Board, August 2025, paragraphs 28 and 45: a 51% increase in ophthalmology referrals between April 2021 and April 2025, and a 30% reduction in the ophthalmology medical workforce between March 2021 and March 2025 (18 to 12.5 whole-time equivalents).

[11] Record of Proceedings, Senedd Health and Social Care Committee, 5 March 2025, paragraph 179.

2. The proposed network

We propose a national eye care network for Wales, known as Eye Health Wales / Iechyd Llygaid Cymru (working title), which Welsh Government would be free to adopt, adapt or replace. It is a three-tier model, aligned to the three regions of the National Clinical Strategy for Ophthalmology, because most coverage plans fail by treating every location as a full hospital. Cataract surgery is the most commonly performed operation in the NHS,[12] and a routine cataract operation does not need a large surgical centre. Split the network into three tiers and the routine majority is treated close to home; only the complex minority travels.

- **Eye hospitals.** Fixed surgical centres carrying the broadest range of procedures — cataract and YAG, glaucoma laser and surgery, intravitreal injections, oculoplastics, selected vitreoretinal surgery — and acting as regional bases for training, governance and consultant cover.
- **Outpatient and diagnostic centres.** A national network of local access points for outpatient appointments, cataract pre-assessment and post-operative review, AMD and diabetic macular oedema injections, glaucoma monitoring and laser, full diagnostics and imaging, and consultant-led virtual review — stood up quickly in existing NHS, primary care or leased premises. How many, and where, would be determined by the specification NHS Wales sets and confirmed by travel-time modelling; our own modelling suggests a network of this kind is what makes a 30-minute access standard achievable.
- **A mobile eye hospital.** A relocatable surgical unit on a published rota, delivering the complete cataract pathway in places that could not sustain a permanent theatre. Deployed first, ahead of any building work — and for parts of Wales, the permanent answer, not a stopgap.



SpaMedica proposed network (illustrative).

Locations and coverage subject to detailed scoping.

[12] The Royal College of Ophthalmologists, National Ophthalmology Database Audit — cataract surgery is the most commonly performed operation in the NHS in England and Wales.

2. The proposed network

Five eye hospitals

The surgical tier is where we would be specific, because it is where the capital, the workforce and the clinical governance sit. The locations are our current thinking, drawn from where demand sits, where people already travel, and what can be built quickly. We would expect to work each one through with Welsh Government and the relevant health board — and we would expect some to move.

SWANSEA - already open and treating NHS patients. Additional theatre and clinic capacity here is the fastest capacity that can be added anywhere in Wales.

BODELWYDDAN - between Rhyl, Prestatyn, Colwyn Bay and Llandudno, on the stretch of coast with the highest concentration of older residents in Wales.

BANGOR - serving Gwynedd, Anglesey and western Conwy. Without it, the north west has nothing within an hour. Bangor also gives access to the clinical workforce around Ysbyty Gwynedd.

CARDIFF AND NEWPORT - deliberately close together. Roughly half the Welsh population lives on the M4 corridor, and no single centre could carry that volume. These two exist for throughput; everywhere else the sites are spaced for distance.

One point we want to be open about: north east Wales. Our starting position is a Welsh-side hospital at Wrexham as the sixth site, if Welsh Government wants one. The alternative — which avoids building over existing capacity — is coverage from Bodelwyddan and from our established hospital at Chester, around 25 minutes from Wrexham, as an interim arrangement. That is a choice for NHS Wales, and we have costed both.

Local access where it matters most

The outpatient tier is where the network earns the word national, and it is also where we are deliberately not prescriptive: NHS Wales should determine where local access is needed, and the specification should say so. What our modelling tells us is about method, not addresses. Fixed local presence matters most where poor health outcomes and low car ownership coincide, as they do in the South Wales Valleys — there, a local centre does more for access than drive time alone suggests. And Powys, the only health board without a district general hospital, currently sends much of its ophthalmology activity to England; local outpatient provision there gives patients a Welsh option and gives Welsh Government a route to repatriating that spend if it wants one.

3. How it would be commissioned

We are not asking NHS Wales to hand eye care to the private sector. We are asking the Welsh Government, working with the NHS Wales Executive and health boards, to specify the network Wales needs, commit to it for long enough that a provider can invest in it, and let providers compete to build it. SpaMedica would expect to bid. So should others.

To be unambiguous about what this is:

- Publicly funded and free at the point of use.
- Delivered to NHS Wales standards and prices, under NHS Wales clinical governance.
- Specified by NHS Wales — coverage, service scope, standards, training obligations, Welsh language provision and outcomes.
- Awarded in open competition.
- No NHS post displaced; no patient asked to pay for care they can receive from the NHS today.
- Built to last beyond any one contract. The end-of-term arrangements belong in the specification, and there are established options to choose from: reversion of the estate to NHS Wales, an option for NHS Wales to acquire the assets, or renewal through further open competition. Under any of them, the capacity built with this investment remains available to Wales permanently — and we accept that private capital is invested on that basis.

Existing and planned secondary eye care budgets, committed for an agreed multi-year period, would be paired with private capital. Wales shapes the service; the delivery partner invests in the hospitals, clinics, equipment and workforce needed to deliver it. The model keeps Welsh funding, Welsh jobs, Welsh training and Welsh infrastructure in Wales.



Wales shapes the service.

The delivery partner invests in the infrastructure needed to deliver it.

Welsh funding | Welsh jobs | Welsh training | Welsh infrastructure

3. How it would be commissioned

The concerns we have heard — and our answers

The Committee was clear that investment in secondary eye care "should support the delivery of services by the NHS, rather than the over-use of the independent sector, particularly for cataract treatment".[13] Witnesses to the inquiry also warned of independent-sector models in England producing surgery of marginal clinical value, drawing the least complex cases, and recruiting staff the NHS has trained.[14] We recognise these concerns, and this proposal is designed to address them:

- **No overprovision:** NHS Wales sets the volumes, the clinical thresholds and the pathways. We deliver to the specification; we do not generate demand against it.
- **No cherry-picking:** the network is multi-specialty by design and would carry complex, lower-margin work alongside high-volume cataract. It would be judged on the NHS capacity it releases, not on cataract volumes.
- **No workforce displacement:** a contractual commitment to net addition — recruiting internationally and training our own, not drawing staff out of health board teams — with training rotations that put capability back into the Welsh NHS.
- **No dependence:** the specification, the standards and the governance stay with Wales throughout, and the estate answer above means the capacity itself outlasts any single provider.

Judged on what it releases, not what it bills

We would report annually, by sub-specialty, on the NHS capacity the network releases and where health boards redeploy it — directly supporting the Committee's Recommendation 5 on sub-specialty waiting-list data.[15] The design principle throughout is complementarity: move high-volume, protocol-driven work out of hospital eye departments, add selected sub-specialist capability currently sent across the border, and hand scarce consultant sessions and theatre time back to the work that must remain in acute hospitals.

[13] Senedd Cymru, Health and Social Care Committee, Inquiry into Ophthalmology Services in Wales, November 2025, paragraph 92.

[14] Dr Andrew Pyott's evidence to the Committee, Record of Proceedings, 20 March 2025; and the Committee's report at paragraphs 34–36.

[15] Senedd Cymru, Health and Social Care Committee, Inquiry into Ophthalmology Services in Wales, November 2025, Recommendation 5.

3. How it would be commissioned

A proven model elsewhere

The structure we are describing — a public payer specifying a service, committing to it for a multi-year term, and contracting a private operator to deliver it under public governance — is not novel. St Göran's Hospital in Stockholm has been run this way since 1999: publicly funded, free at the point of use, and operated by Capio under a contract competitively tendered by Region Stockholm, most recently re-awarded in October 2024 for a term running to 2034 and beyond.[16] Analysis for Monitor, then the NHS regulator, found the regional payer paying around 10% below the standard tariff, with patient satisfaction and emergency waiting times at least as good as comparable public hospitals, and Region Stockholm's own 2015 benchmarking found lower cost per case and slightly higher patient-rated and clinical quality than its two public comparators.[17] A quarter of a century in, the model has survived changes of government of both political colours — because the region keeps the specification, the governance and the choice of operator.

Wales does not need to look abroad for the principle, only for the scale. Our Swansea hospital already operates on the same basis — publicly funded, NHS-governed, free at the point of use — for the patients NHS Wales sends to it. This proposal applies a proven mechanism to the whole country.



[16] Region Stockholm, Health and Medical Care Board award decision, 22 October 2024: contract for the operation of St Göran's Hospital awarded to Capio for eight years from January 2026, with a four-year extension option. The hospital has been operated by Capio under contract since 1999.

[17] 'International comparisons of selected service lines in seven health systems', evidence report commissioned by Monitor and prepared by McKinsey & Company with Nigel Edwards of the Nuffield Trust, October 2014, Annex 16: Emergency pathway at Capio St Göran Hospital; and Stockholm County Council, Hälso- och sjukvårdsförvaltningen, 'Benchmarking av akutsjukhusens effektivitet: Danderyds sjukhus, Capio St Görans sjukhus och Södersjukhuset', March 2015.

4. Workforce and Welsh language

A network of this size cannot be staffed from the existing Welsh consultant pool, and we would not propose to fly teams in. Our commitment is a net addition to the Welsh ophthalmic workforce:

- Up to 175 new Welsh healthcare jobs, recruited without drawing staff out of health board ophthalmology teams — through international recruitment and our own training pipeline.
- Training rotations for surgeons, nurses and optometrists, with up to 80 student and clinical placements a year and regional training suites at each hospital.
- Joint staffing and local secondments with health boards, so NHS careers are strengthened by the network rather than competed against.
- Workforce terms settled in the specification. We would expect the discussions to cover how terms and conditions are framed — including the case for alignment with NHS terms and for recognition arrangements — and we are open to the range of approaches used in comparable arrangements.

On Welsh language: in line with *More than just words*, we would deliver the active offer at every site, with Welsh-speaking staff recruited and rostered locally — specified and measured site by site, not treated as a general commitment. Bangor and the north west are planned in part around access to Welsh-speaking clinical staff.



5. Why SpaMedica can say this credibly

SpaMedica at a glance — figures from our published Quality Account 2025/26:[18]

A leading national provider

The UK's largest independent provider of ophthalmology services, delivering care from **73 locations** including **64 hospitals**, with contracts in place at 31 March 2026 across 40 of the 42 English Integrated Care Boards and with Welsh health boards. Our sister company, Veonet Ireland, delivers ophthalmology services from locations in Belfast, Cork and Dublin. More than **1.18 million** NHS referrals accepted since 2020, including around **14,400** at our Swansea eye hospital since 2023.

Outstanding clinical outcomes

- **99.5%** of procedures completed without complication
- **96%** of patients achieving 6/12 vision or better (national target 95%)
- **0.48%** posterior capsule rupture rate (national range of 0.5–1.5%)
- **0.001%** endophthalmitis rate against a benchmark of 0.1%.

Quality recognised by patients and regulators

Every CQC-rated location rated Good or Outstanding — **36 rated locations**, of which **12 are Outstanding** — with a median referral-to-treatment time of **4.7 weeks** and a patient Net Promoter Score of **92.**

Invested in training and the workforce

A training provider at national scale: more than **11%** of clinical activity delivered by trainees under structured supervision, with trainee outcomes exceeding national benchmarks, recognised by the LaingBuisson Award for Excellence in Training.

Delivering in the community

A community delivery model working with over **6,000** community optometrists, who completed more than **120,000** post-operative checks in 2025/26 — and free patient transport as standard, used by **32,279** patients in 2025/26.

A multi-specialty clinical network

A multi-specialty clinical network already delivering cataract and YAG, wet AMD injection therapy, glaucoma, oculoplastics, vitreoretinal surgery and hydroxychloroquine monitoring.

[18] SpaMedica Quality Account 2025/26, published June 2026, available at spamedica.co.uk. Unless otherwise footnoted, all figures in this section are drawn from the Quality Account and relate to the year to 31 March 2026.

5. Why SpaMedica can say this credibly

What Swansea currently delivers reflects what has been commissioned there, not the limit of what the network can do.

Four of our hospitals — Chester, Hereford, Telford and Bristol — already sit on or close to the Welsh border, treat Welsh patients today and need no further investment. They are part of how the network works from day one and reduce what has to be built inside Wales. But they are support, not the destination: the purpose of this proposal is that patients in Wales are treated in Wales.

We already run the mobile model this network relies on — a treatment centre on the Isle of Wight, community diagnostic and treatment centres in Leeds and Sheffield, and in Hereford the UK's first relocatable diagnostic and treatment centre, delivering assessment, cataract surgery, YAG laser and post-operative care from one community facility, with patients treated in as little as four weeks. The estate is not the difficult part. Getting the rota right is, and that is planning work we would do with health boards against real referral volumes.

Once a site is agreed, a surgical centre can be operational within 12 weeks and an outpatient clinic within 6. The mobile hospital deploys sooner than either.



6. What we are asking for

We are not asking for a decision about SpaMedica. We are asking Welsh Government to test whether a network of this kind can be commissioned — and to do that now, rather than after another planning round. Specifically:

A formal market engagement exercise on a multi-year, multi-specialty ophthalmology network for Wales.

Consideration of that network in the National Clinical Services Plan and the surgical hubs programme, so the multi-year commitment the investment case depends on can be made.

The Committee has asked for action in months, not years. A market engagement exercise commits Welsh Government to nothing except finding out what is possible — and it is the fastest available way to answer the question the Committee has posed. If the specification that follows is one another provider can meet better than we can, so be it. What matters is that NHS Wales stops buying eye care a year at a time.

We would welcome the opportunity to discuss this proposal with Ministers, officials and the Health and Social Care Committee.

Contact:
Richard Peric-Matthews
NHS Trust Partnership Director
SpaMedica

richard.pmatthews@spamedica.co.uk

Appendix A - **The conversation we are asking for**

This proposal deliberately stops short of a delivery plan. Sequencing, site-by-site detail and contractual structure will all be shaped by the specification Wales sets and would change in the shaping — so we would rather bring the method to the table than present conclusions. What we are asking for is a series of working discussions with Ministers, officials and NHS Wales on three questions:

- **What the service could look like.** The shape of a national network — surgical hubs, local outpatient access, mobile capacity — tested against health board plans, travel-time modelling and the National Clinical Strategy's regional model.
- **How delivery could be supported.** Where our delivery record — high-volume surgery, multi-specialty services, rapid site mobilisation, workforce development and patient transport — can be applied to the problems the Committee has identified.
- **What a procurement and specification could look like.** The realistic contracting routes open to NHS Wales, the term needed to support capital investment, and the safeguards — governance, workforce, estate — Wales would want written in.

One structural point we would raise early, because it bears on how the specification is framed: rural provision is the hardest part of any network to sustain on its own. It works when the network around it carries volume, which is the argument for commissioning this as one arrangement rather than health board by health board.

How we would approach it

- **Confirm the map before committing the capital.** Formal travel-time modelling, weighted to population at small-area level with a public transport overlay, tested against each health board's plans. We would rather change the map early than defend the wrong one later.
- **Work around existing plans, not across them.** Hywel Dda's Clinical Services Plan, Cardiff and Vale's regional centre of excellence and Aneurin Bevan's cataract hub arrangements are live. Our starting assumption is that we add capacity around them.
- **Use what Wales has already built.** Wales General Ophthalmic Services already supports referral filtering, monitoring and post-operative checks in community optometry. For the most remote communities that is a better answer than more buildings. We would contract into it, not around it.
- **Take the travel burden off the patient.** Free patient transport is part of our standard model and already runs from Swansea.

Appendix A - **The conversation we are asking for**

Questions the discussions would need to resolve



Whether the network is commissioned nationally or health board by health board, given that rural provision is realistically only sustainable inside a single arrangement.



Where the balance is struck between local access and concentration of complex care.



Whether north east Wales should have a hospital of its own from the outset.



How the outpatient tier is specified — the access standard to be met, and the role of community optometry alongside fixed centres.



How Welsh language provision is specified and measured at each site.



Whether Powys activity currently going to England should be repatriated, and over what period.



How training places and clinical supervision are shared between the network and health boards.

Appendix B - **In their own words**

Our patients

"My experience at SpaMedica Swansea was amazing. I was so frightened and nervous — I had no reason to be at all. The surgery took six or seven minutes on both occasions. Now I can see clearly in both eyes."

John Pugh, patient, Swansea, July 2026

Our people

"I love working at SpaMedica in Swansea because we make a genuine difference to people's lives. Helping patients regain their vision and independence is incredibly rewarding and I'm so proud to be part of such a caring team."

Grace Arthure, nurse, SpaMedica Swansea

Our NHS Wales partners

"By providing services closer to home, SpaMedica has helped reduce travel times for Welsh patients, making access to treatment more convenient and less stressful… By working together, we continue to deliver safe, effective care and to improve services for the people of Wales."

Swansea Bay University Health Board

"SpaMedica has consistently demonstrated reliability and integrity, delivering on the commitments they have made… By providing high-quality ophthalmology services closer to home, SpaMedica has helped improve access to treatment, reduce waiting times and enhance the overall patient experience, while maintaining exceptional standards of clinical quality and safety."

Jason Hewson, Ophthalmology Service Management Team, Hywel Dda University Health Board

SpaMedica

