



## **Our ophthalmology service is “failing”, please help!**

The Royal College of Ophthalmologists has been asked by a number of health care organisations across the UK to conduct [reviews of ophthalmology services](#) during the last decade. Immediate triggers for the requests have included complaints, adverse events, staffing problems, difficult relations between clinicians or between clinicians and managers and problems meeting waiting time targets. However, a very common finding has been that, underlying the stated reason for the request, there is a chronic mismatch between capacity and demand within the service.

Although this fact has usually been recognised, the response to it has often been reactive and sporadic rather than forward-looking and concerted. Short term expedients such as waiting list initiatives may have been tried. There is often disagreement about whether there is a fundamental shortfall in capacity or whether existing capacity could be better used. Simplistic solutions are frequently offered – for example: “we just need another consultant”, “they just need to discharge more patients to the community”, “theatre utilisation just needs to be improved”. Under these circumstances, clinicians, managers and commissioners may start to blame each other for being inefficient or inflexible or failing to understand the true situation.

It has to be acknowledged that some ophthalmology services are at an inherent disadvantage when compared with others, for reasons of difficult geography, crumbling estate or a legacy of poor organisational planning. There may not be quick or easy solutions to all of these problems.

The aim of a College invited review under these circumstances is to assist the organisation in developing an ophthalmology service that provides safe and effective care in a sustainable way. Typically, the review recommendations focus on three main areas:

1. Population needs assessment
2. Quality indicators
3. Workforce planning and training

## Population needs assessment

It is usually possible to undertake a population needs assessment for an ophthalmology service quite rapidly as a paper exercise. The data needed for this exercise will be in the public domain and readily available.

### *1. How many people does the service cover?*

The size and age profile of the local population should be readily available from public health data <http://www.england.nhs.uk/la-ccg-data/#ccg-info> or <http://www.ons.gov.uk/ons/search/index.html?newquery=population+by+CCG>. It should be possible to refine this to estimate the size of population effectively served by the ophthalmology service by taking into account known patterns of cross-boundary flow in and out of the area. It is important to know whether the age profile of the population differs significantly from the national average, as many eye conditions increase in prevalence with advancing age (particularly the “big four” conditions of cataract, age-related macular degeneration (ARMD), diabetic retinopathy and glaucoma). The ethnic profile of the population may influence the prevalence of eye conditions significantly (particularly glaucoma and diabetic retinopathy) and high levels of social deprivation may be associated with an increased tendency for people to present with advanced disease (glaucoma, diabetic retinopathy) when treatment may be more difficult and expensive, or an increased propensity to bypass primary care providers (GPs and optometrists) in favour of accident and emergency departments.

In some areas of the UK, the process of defining the population served by the ophthalmology service may be complicated by the existence of contracts between commissioners and non-NHS providers to provide some NHS ophthalmology services. This may for instance result in the NHS unit seeing a higher than expected proportion of patients with complex eye problems or multiple co-morbidities.

### *2. What level of provision is likely to be required for this population for the main eye conditions?*

Currently, few ophthalmology services have access to information systems which systematically collect and code data about the primary diagnosis and co-morbidities of patients presenting to them. One exception to this rule is diabetic retinopathy, which is monitored by UK-wide screening programmes, though even here, accurate estimates of the prevalence of sight-threatening diabetic retinopathy are critically dependent on reliable and timely return of diagnostic information to the failsafe database for patients being cared for in the hospital ophthalmology service.

For most other eye conditions, it will be necessary to extrapolate national estimates of incidence and prevalence to a local population in order to predict how many outpatient appointments, visual fields, intravitreal injections, theatre slots, retinal images etc. will be required to manage these conditions safely and effectively.

It is particularly important to gain a reasonably accurate picture of the prevalence of ARMD, glaucoma, diabetic retinopathy because of the need for long-term or life-long

monitoring of patients with these conditions

<http://www.rnib.org.uk/aboutus/Research/statistics/Pages/sight-loss-data-tool.aspx>

there has been considerable interest in the possibility of transferring the care of patients with these conditions from hospital to a community setting, the availability of the necessary expertise, suitable premises and equipment to allow a safe standard of care often limits the ability to achieve this goal. The College's paper '[New to follow up \(N:F\) ratios in ophthalmology outpatient services](#)' provides an analysis of the scale of follow-up provision likely to be required and demonstrates clearly the inappropriateness of the application of new-to-follow up ratio targets to these long-term conditions.

### *3. What emergency and "tertiary" services does the unit need to provide?*

A generation ago, most ophthalmology units provided first-contact care for most types of eye problem. Most had access to inpatient beds and most provided an out-of-hours emergency service. Today, the treatment of cataract, ARMD, glaucoma and diabetic retinopathy forms the core of the workload of most ophthalmology units. Few units have dedicated ophthalmic inpatient beds and many units that formerly provided 24 hour emergency cover no longer do so. The reasons for this change include the European Working Time Directive which has rendered on-call rotas in small units unsustainable and increasing sub-specialisation within ophthalmology.

Factors which influence the range of sub-specialty services and the availability of urgent care within ophthalmology units include the unit's size, proximity to university and research facilities, "teaching" status, distance to other ophthalmology units, transport links, historical patterns of referral, the wishes of commissioners and the sub-specialty interests of its consultants. A decision to change the range of sub-specialty or urgent-care facilities provided by a unit can have a major impact on the distances patients must travel to receive care and sometimes on other clinical services in the same hospital (e.g. paediatrics).

## **Quality Indicators**

The systematic application of quality indicators to ophthalmology services is still in its infancy, but is already beginning to inform decisions to commission or decommission ophthalmology services and will do so to an increasing extent.

The College has developed a suite of simple [self-assessment questionnaires](#) covering services for cataract, glaucoma, diabetic retinopathy, ARMD, vitreoretinal surgery, oculoplastic surgery and ophthalmic services for children and young people. These are intended primarily to be used as local quality improvement tools to answer the question "Is the service performing better or worse than it was when last audited?", rather than to rate the service as good, fair or poor, or to compare it with a service provided by another unit. Nevertheless, a low score is likely to indicate that a service is struggling as the questions focus on aspects of patient care that are likely to struggle if the service as a whole is under stress.

A frequent question asked of College invited reviews is “What is the minimum (or maximum) number of patients that a clinician should be expected to see in an outpatient clinic?” The answer to this question should start by considering the appropriate amount of face-to-face clinical time that should be allocated per patient. It is important that this includes adequate time for discussion of findings with the patient and record-keeping as well as for the assessment itself. The College recommends that this should be not less than fifteen minutes per patient, and may need to be significantly more for clinics where most patients have complex conditions, or require outpatient procedures such as laser treatment, for example. See the College advice on the [Ophthalmic Outpatient Department](#).

Where an ophthalmology service is failing to meet the demands made on it to a significant degree, it is particularly commonly evident in the following areas:

- Frequent hospital-initiated cancellations of outpatient follow-up appointments, particularly at short notice
- Repeated rescheduling of follow-up appointments
- Large numbers of patients on partial-booking lists who are overdue for follow up appointments
- Patients with glaucoma have follow up intervals significantly longer than the planned follow up interval
- Failure to deliver timely assessment and treatment for sight-threatening diabetic retinopathy
- Failure to adhere to treatment and assessment schedules for patients receiving treatment for ARMD
- Over-booking and over-running of clinics occurs routinely
- Difficulty in accommodating requests for urgent appointments
- Ophthalmologists in training are frequently taken out of theatre or study sessions to cover clinics
- A higher than expected number of complaints from patients and referrers, particularly regarding difficulty in obtaining appointments or failure to return phone calls.
- A higher-than expected number of safety incidents or near misses, or a tendency for safety incidents to come to light by routes other than the normal reporting mechanisms.

Periodic structured audits of a sample of case notes can be a very valuable exercise to ascertain the frequency and impact of significant events such as postponed appointments, or failure to adhere to treatment schedules. A review of appointments data against clinic profiles can help to ascertain the scale of overbooking.

## **Workforce planning and training**

It is not possible to undertake a meaningful review of an ophthalmology service without taking into account the roles and skills of the people who contribute to the service. The sustainability of an ophthalmology service depends on having both the right numbers of health care professionals and the right mix of skills to meet the needs of the population.

Predicting the numbers of health care professionals likely to be required to meet the demands of the service is generally a logical extension of the population needs assessment described above. However, different units will need to take different approaches to this. A large teaching hospital service is likely to have a reasonable number of specialty registrars, perhaps supplemented by clinical fellows who are undertaking advanced sub-specialty training. However, an ophthalmology service in a remote rural area may be run entirely by consultant ophthalmologists and nurses, optometrists or orthoptists with extended roles.

A service may be thrown into crisis because of the loss of a key member of staff through retirement or other reasons. It may not always be possible to replace a member of staff quickly with someone with equivalent interests or aptitude, particularly where a job-role has been built around an individual. It is therefore vital that units consider not only their immediate workforce needs, but the need for succession planning so that they do not become excessively dependent on key individuals.

There is plenty of scope for professionals other than ophthalmologists to take on many roles and tasks which have been undertaken mainly by ophthalmologists in the past. However, it cannot be assumed that it will be possible to appoint someone who already has all the necessary skills, and it may be necessary to appoint someone with a view to training them for the required role. It may be particularly challenging to maintain an urgent-referral or out-of-hours service with relatively small numbers of staff.

The training and supervision of ophthalmologists or other health care professionals requires dedicated time which must be factored into workforce planning. When an ophthalmology service is struggling, it is very likely that this will have adverse effects on training, with training time being sacrificed to service pressures.

## **Summary**

There may be many reasons for an ophthalmology service struggling to meet the demands placed upon it. However, the themes identified in this paper have been relevant to most invited reviews undertaken by the College over the last decade and should be considered by organisations whose ophthalmology service appears to be in difficulty.

Mr Richard Smith on behalf of the Professional Standards Committee

July 2013