1 February 2017

The ROYAL COLLEGE of OPHTHALMOLOGISTS

18 Stephenson Way
London, NW1 2HD

T. 020 3770 5334
president@rcophth.ac.uk

rcophth.ac.uk
@RCOphth

FROM THE PRESIDENT

Professor Caroline MacEwen
MD, FRCSEd, FRCOphth,
FFSEM, FRCP(Ed)

Pauline Fyfe
Programme Manager
Delivering Outpatient Integration Together (DOIT)
Directorate for Health Performance and Delivery
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Dear Ms Fyfe

Re: The Modern Outpatient: A Collaborative Approach 2017-2020

The Royal College of Ophthalmologists welcomes the opportunity to respond to this consultation. We are the professional body for ophthalmologists and we champion excellence in the practice of ophthalmology on behalf of our members to optimise care for patients. We work with leaders across the eye health sector to help shape eye services for the benefit of patients, and provide guidance on commissioning ophthalmology services.

The document contains many themes that mirror work undertaken by The RCOphth to try and address the lack of capacity for current demand with emphasis on safety and quality of service and the need to train an expanded ophthalmic workforce. The Way Forward Project has explored new models of care and ways of working to benefit patients and the Ophthalmology Common Clinical Competency Framework identifies the training required to develop skills for expanded roles.

Ophthalmology as a speciality has been working towards streamlining outpatient services for some time and many of our members in Scotland and across the UK will recognise some of the suggestions as activities they have already started to implement in their own departments e.g. the NHS Grampian Eye Health Network as this saves approximately 12,500 appointments in the Urgent Referral Clinic per annum and if rolled out across Scotland could theoretically prevent 125,000 new appointments.

To effect the changes described in this document will require a cultural change in some quarters, funding for adequate ophthalmic software, staff development and recruitment/retention and investment in community infrastructure. The Ophthalmology Common Clinical Competency Framework is well timed to support the recognition of staff

training needs. Ophthalmology could make significant changes which would reduce the number of hospital consultations and minimise unnecessary consultations. This would require working with optometry to establish a post-registration training for optometrists in hospital eye departments. It would also have the double benefit of alleviating workforce gaps, particularly in smaller units, and developing a cohort of optometrists with the skills to co-manage patients who currently attend the HES for all follow-up appointments and manage a greater range of patients independently.

The RCOphth advocates the need to improve software that will support ophthalmic care and electronic links for information when patients are seen in different locations by different health care professionals. This will make the patient journey more efficient and also aids the ability to undertake high quality audits e.g. identifying outliers in referral rates. Better communication and feedback, aided by improved IT arrangements, can help raise standards in relation to referrals into the hospital, care outside of the hospital and new ways of working e.g. virtual clinics. Better IT/connectivity to improve data sharing might involve less patient movement in the remote and rural areas if high-resolution broadband service can be established with optometrists in Scotland (and across the UK). This would allow optometrists to include a consultant ophthalmologist into a live consultation remotely where needed so that there can be verbal interaction, demonstration of physical signs, slit lamp examination and sharing of images.

It is recognised that Scotland has made huge steps to improve this situation and the right infrastructure and skills need to be in place to support this. The IT support for this is vital and in practice is difficult to achieve e.g. people with sight impairment often prefer to receive their appointments electronically so they can enlarge and alter to make it easier to see. However locally, clinicians in Scotland report that they cannot email a patient an appointment because of data protection/ governance issues so Skype appointments in the home are a step change from this.

There are some elements of the proposals that require further consideration. The RCOphth is concerned that the document assumes capacity is present within the community to deliver these changes. We would challenge this assumption. GP services are reported to be overstretched and we do not believe that current capacity or expertise exists in local community optometric services to deliver significant shared care schemes. The ability to access a community physiotherapist in a timely fashion is impossible and limited when it becomes available – but quoted as an exemplar of how to transfer care to community. It is not realistic to expect the proposals to come into effect by April 2017. The Hospital Eye Service in Scotland does include a limited number of non-medical personnel with the skills to take on advanced tasks. However, a review of recruitment and a continued education and career pathway needs to be developed for these roles.

Any programme of change in hospital and community services requires time and financial investment to ensure the structures and appropriately trained personnel are in place. In the community transfer of care needs appropriate education, training and governance arrangements. Another aspect to consider is that almost all Ophthalmic Specialist Training (OST) for ophthalmologists is hospital-based. An assessment should be made on the

potential impact on training if more care is moved to the community. New training opportunities for training in the community will be required.

A reduction in investigations is desirable for patients and the service as a whole. However, it is recognised that fewer investigations are requested by specialists than by generalists and junior doctors, as specialists have the deeper knowledge to make clinical judgements and order more focused and relevant investigations; expertise and experience improve confidence in clinical skills and disease management.

The proposals on self-management many not translate to ophthalmology care as there is a need to carry out examinations especially for chronic disease monitoring and management e.g. glaucoma, age-related macular degeneration.

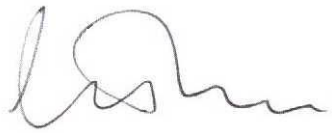
There are examples in the UK that demonstrate joint working especially with optometrists delivering eye care in the primary care/community setting. However, it remains unclear if these schemes have actually helped to reduce overall costs and there is also a lack of audit as to outcomes of those patients not referred to hospital or the need for duplication of services or delayed patient access to secondary care. Attempts to reduce the workload of hospital eye departments by increasing the provision of primary eye care clinics for minor non-urgent eye conditions will be unsuccessful if large numbers of patients with minor eye conditions continue to bypass the primary care service on the grounds of perceived urgency and attend out of hours' emergency departments. The schemes have operated in areas where the local hospital previously offered a 'walk in' service to which patients could self refer. The results therefore cannot be extrapolated to eye departments which run referral only emergency services (from GPs, optometrists and local A&E departments).

The document seems to concentrate on the existing capacity and demand problems but does not include data around estimated increase in demand based on demographics and epidemiological studies. The Way Forward Project produced by The RCOphth indicates a significant increase in the demand for eye care services over the next 10 and 20 years.

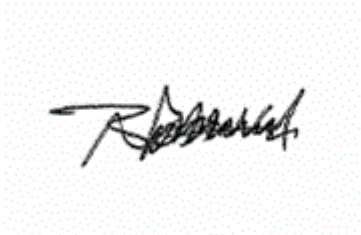
The document appears to be designed for people already diagnosed and in the system. For people who are newly experiencing symptoms it is less clear how they will be diagnosed and enter the system. Improving the confidence of patients to access care when they need it is essential. Currently getting access to care can be opaque to patients – especially those who are unwell (i.e. need help) or are one of the hard to reach groups. The increased attendances at A&E departments are testament to patients' recognition of ways to enter the system. Anxiety about self-care cannot be over-emphasised and may lead to unnecessary health seeking behaviours.

The proposals are welcomed by the RCOphth and in order to become an effective change, more 'out the box' thinking needs to be included. For ophthalmology (and many other specialties) – training of non medical Health Care Professionals needs to become more clinically based and occur within hospital departments and funding streams that intrinsically separate care in different environments should be dismantled to promote better cross sector working

Yours sincerely



Professor Caroline MacEwen, MD, FRCSEd, FRCOphth, FFSEM
President



Mr Bernard Chang FRCOphth
Vice President
Chair of Professional Standards